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Mental health needs assessment : the Guamanians in California.

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MENTAL HEALTH NEEDS ASSESSMENT:

THE GUAMANIANS IN CALIFORNIA

A Dissertation Presented

By

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TABLE OF CONTENTS

LIST OF TABLES

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ABSTRACT

Mental Health Needs Assessment:
The Guamanians in California

September, 1982

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This dissertation reports the findings of a survey designed to establish baseline information on the mental health service needs of Guamanian Americans living in Northern California. Additionally, the identification of respondents' human service utilization patterns and natural helping network was sought.

Varying levels of needs for mental health services were outlined by the respondents' scores on the following five psychiatric symptom and dysfunction scales: (1) a depression scale, (2) an anxiety scale, (3) a cognitive impairment scale, (4) a psychosocial dysfunction scale, and (5) a general psychopathology scale. The working premise assumed that psychiatric symptoms and related dysfunction are not randomly distributed, but rather cluster among certain social and demographic groups. Therefore, when psychiatric scale scores are high for subpopulations that share a particular characteristic, such as age, sex,

marital status, and education, it is assumed that these elevated scores are related to the group's degree of vulnerability to life stressors. The research discriminated between mental health service needers and non-needers on the basis of statistical distributions of psychiatric symptoms and function levels.

The findings reveal that low socioeconomic status, particularly low household income and low educational attainment, were found to be the strongest predictors of high scores and high needs for mental health services.

The low utilization rate for mental health services among Guamanian Americans suggests that they are apprehensive about seeking help from a community mental health center. Their apprehensiveness can be partially attributed to their limited awareness of the services provided by a community mental health center, but also because of personal embarrassment and fear. These issues need to be understood and modified in order to facilitate closer ties between the mental health service delivery systems and potential service users.

PREFACE

The idea for this research came from the author's interest and concern about the general well-being of Guamanian Americans living in the United States. Although Guamanian Americans have immigrated into the United States in increasing numbers during the past decade, virtually nothing is known about their mental health service needs or the extent to which human service delivery systems are effective in ameliorating their psychosocial problems.

Guamanian Americans are often mistaken as members of other better-known ethnic groups, which exposes them to similar social, economic, and political inequities that have victimized Blacks, Chicanos/Latinos, and Native Americans. The consequence of this victimization is that, despite recent efforts to promote civil rights and equal opportunities for ethnic minorities in the United States, Guamanian Americans have also been largely ignored by national, state, county, and local agencies, educational institutions, and health care service providers.

Guamanian Americans are not a visible ethnic group and as such, they have yet to emerge as a distinct and organized community that can effectively advocate for their own social, political, and economic needs. It is hoped that

this research will contribute helpful baseline information to the Guamanian American communities and other human service decision makers who are interested in promoting a more responsive effort to meet the social and mental health needs of Guamanian Americans in the United States.

C H A P T E R I

INTRODUCTION

America is a country populated by persons of varying cultural, linguistic, and racial backgrounds. Indeed, America is a country of immigrants; a land made great because of its diversity and multi-cultural heritage. As a result of the past two decades of civil rights and advocacy activities, the ethnicity of potential service populations has come to assume significant importance in the planning for and the implementation of federal, state, and locally mandated programs in health, mental health, and human services. Yet, amidst this heightened awareness, numerous smaller and less visible cultural groups are only now receiving recognition; Guamanian Americans are such a group.

The Federation of Guamanian Association of America estimated that there are approximately fifty-five thousand (55,000) Guamanian Americans living in California, with smaller numbers residing elsewhere in the continental United States, Alaska, and Hawaii.[1] However, the 1980

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[1]The Federation of Guamanian Associations of America, "Estimate of Guamanian Population in California, as of October 18, 1978" in Pacific Islander Health and Health Care Workshop Final Report, Center for South Pacific Studies, University of California, January 13-14, 1979.

U.S. Census reports only 32,132 Guamanian Americans in the entire United States, with 17,673 Guamanian Americans living in California.[2] It should be noted that this is the first U.S. Census that included Guamanians as a specific ethnic group and there is a real possibility of under-enumeration.

Guamanian Americans have migrated to the United States in significant numbers for the past three decades. However, there has been little direct study devoted to the mental health needs and health related services of Guamanian Americans. This dissertation will focus on a research design that will provide baseline information regarding the mental health service needs of Guamanian Americans in Northern California.

Problem Statement

Guamanian Americans, like other Pacific Islanders, are often confronted with social and cultural changes and differences associated with starting a new life in the United States. Some individuals will adjust and benefit from the changes, while others will not or cannot fully adjust to their new environment. Social and cultural changes can be stressful, if for no other reason than the replacement of the familiar by the new. How well Guamanian

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[2]State Census Data Center, Population Research Unit, Department of Finance: U.S. Census Bureau, December, 1981. Asians in the United States, California Bay Area.

Americans cope with the changes will depend on the resources they have and the support networks that are available to them upon arrival in the United States.

It is difficult to obtain an accurate understanding of how well Guamanian Americans are adjusting, because of a lack of basic socio-demographic and health information. To date, much of the general information regarding the well-being of Guamanian Americans has been gleaned from peripheral fragmentary impression, ad hoc opinions, and stereotypes.

As a member of the Guamanian American Community in Northern California, the writer has had the opportunity to become familiar with a number of information sources. In consolidating these resources, it appears that there are two major themes that are generally used to describe the general well-being of Guamanian Americans. One theme states that, generally, Guamanian Americans are not experiencing any major adjustment problems or problems different from the larger community and are well integrated into their new environment.

The second position states that a large number of Guamanian Americans are having real difficulty in starting a new life in the United States, but that these difficulties go unnoticed because Guamanian Americans are too proud or ashamed to admit to problems or to seek help from outside the extended family.

The lack of documented information and these prevailing polarized opinions regarding the general well-being of Guamanian Americans in the United States becomes the focus of this research; to investigate and evaluate the mental health service needs of Guamanian Americans in Northern California.

Premise

The working premise of this research is based on the assumption that psychiatric symptoms and related dysfunction are not randomly distributed, but rather cluster among certain social and demographic groups. In other words, when psychiatric scale scores are high for subpopulations which share a particular characteristic, e.g., age, sex, marital status, education, and/or socio economic status, it is assumed that these elevated scores are related to the group's degree of vulnerability to life stressors.

Testing this premise will provide a mental health service needs profile for the Guamanian American Community in Northern California, which should be considered a beginning, a foundation upon which additional needs assessment data can be integrated.

Research Questions

Guamanian Americans are faced with abrupt social and cultural changes upon arriving in the United States. They

are no longer the majority group and must adjust to shifts in hierarchical structuring within the new environment and modify their lifestyles, values, and beliefs as they pertain to patterns of human interaction and to the utilization of objects of material culture and technology in the United States. These immigrants often have to establish new support systems, and at the same time, try to meet the immediate needs associated with starting a new life. Faced with problems associated with a migration experience, Guamanian Americans become vulnerable to psycho-social stresses related to their economic insecurity and culture shock.

Therefore, in order to understand how well the Guamanian Americans are adjusting, this research proposes to seek answers to the following questions:

1. What are the mental health service needs of Guamanian Americans?
2. What are the primary natural helping networks of Guamanian Americans?
3. What are the human service utilization patterns of Guamanian Americans?

Theoretical Background

The theoretical basis for the research was derived from the concepts of Social Psychiatric Impairment (SPI)

developed by Schwab, et al.[3] The Social Psychiatric Impairment concept recognized that all health, illness, and needs arise in a social setting and mental illness, to a large extent, is culturally defined. Furthermore, differential rates of health, illness, and needs are associated with socio-demographic factors, such as income, availability of human services, and the type of help received--all of which is socioculturally determined.[4]

The Social Psychiatric Impairment concept is derived from social science and psychiatric models of impairment. However, it goes beyond the limitations of the medical model, in that it acknowledges the subjective, the interpersonal and the larger social ramifications of personal distress, behavior disorders with their interpersonal consequences, and deviance with its societal implications. It encompasses three dimensions of psychosocial distress: (1) traditional definition of psychopathology, (2) levels of functioning at home, work, and in the broader social arena, and (3) the quantity and quality of interpersonal relationships.[5] Social Psychiatric Impairment is operationally defined as the disturbance felt by the individual, by his/her difficulties in functioning according to societal expectations, and by interpersonal distress.[6]

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[3]John J. Schwab, et al., Social Order and Mental Health: The Florida Health Study (Brunner/Mazel, Inc., 1979).

[4]Ibid., p. 53. [5]Ibid. [6]Ibid.

One of the most difficult tasks that was confronted in this research was that of defining the phenomena under study, i.e., what are mental health needs and how can they be identified empirically? Regrettably, at present there is no commonly accepted definition or procedure to make such a determination. Furthermore, a number of socio-cultural factors complicate attempts to define mental health or illness with precision. Any definition is largely dependent upon individual group norms and tolerance. Behaviors considered flagrantly abnormal at one time may be thought normal a few decades later. This is exemplified by the changing definitions of some former behaviors, such as homosexuality, which were considered abnormal in the earlier Diagnostic and Statistical Manual of Mental Disorders (DMS) and which are not considered so in the DMS III.

Although there is little doubt that mental illness exists and can be found in every culture, these definitions are influenced by cultural relativity and changing norms. Such difficulties in defining mental health are illustrated by Machado de Assis' classical story, "The Psychiatrist," written in the 1890's.

> A highly esteemed psychiatrist in a Brazilian province was empowered to build a mental hospital. In seeking scientific criteria to determine who should be admitted, he reviewed his medical knowledge and searched the writings of philosophers and theologians. He found that obvious psychopathology was an insufficient criterion and concluded that mental illness was evidenced by a disturbance of reason or the mental faculties--a deviation from Aristotle's "Golden

> Mean." Using this criterion, however, it was necessary to confine most of the population because "imbalance" was so prevalent--characteristic of the majority. Therefore, he re-evaluated his criteria and decided that perhaps the mentally ill were, in reality, the remaining few who appeared to be balanced, despite the chaos, revolution, and social unrest in the province. Eventually, almost everyone was hospitalized at one time or another, according to the criterion "in vogue" at the time. Realizing that scientific precision had not been achieved, the psychiatrist finally released all of the inmates and with supreme logic, incarcerated himself as the sole patient.[7]

Establishing a standardized definition and measurement procedure for mental health that would be acceptable to all social, behavioral, and medical disciplines is still a long way off and may never be accomplished to the satisfaction of all concerned. However, the absence of consensus on these issues should not deter research. The current discipline will move forward only as researchers and practitioners from a number of areas approach the theoretical and methodological issues from their particular perspective. The diversity and complexity of the world we live in warrants a multi-disciplinary approach to the field of mental health.

Limitations of the Research

All survey research is, to some extent, plagued by methodological constraints which affect the interpretation of the data, and certainly this research effort is no

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[7]Machado de Assis, "The Psychiatrist," in de Assis' The Psychiatrist and Other Stories, trans. William L. Grossman and Helen Caldwell (Berkeley and Los Angeles: University of California Press, 1963).

exception. The purpose of this section is to describe a major source of bias in the data base that will provide the reader a basis for the cautious assessment of the findings.

It was recognized at the onset that a major source of bias, from a statistical point of view, would be the representativeness of the sample frame. Achieving a representative sample frame presented a difficult methodological problem, since there were no accurate listings of Guamanian Americans in any of the three counties from which the sample was to be drawn and the spatial dispersion of their households precluded geographic stratification. Therefore, the researcher compiled a master list of Guamanian Americans over the age of eighteen from secondary sources (Guamanian Clubs' membership rolls, privately owned address books, and respondent referrals) which came to represent the sample frame.

The representativeness of the sample population was completely dependent upon the comprehensiveness of the master list, but the degree to which the sample frame was representative is not determinable. The sampling bias had the potential of not including those persons who live in isolation (so-called social isolates) and do not belong to any Guamanian organizations. This would have been a serious limitation because the aim of this research was to determine overall mental health service needs. The

exclusion of social isolates may skew the results and present a more favorable profile of the Guamanian Americans.

There is a strong presumption that persons who are members of organizations may be thoroughly settled in and, as such, their mental health service needs and human service utilization patterns may be quite different from those persons who are social isolates and who do not participate in any social or ethnic organizations. Furthermore, it is speculated that the sampling procedures employed by the research, which depended heavily on a networking approach, would prove more helpful by most criteria in reaching social isolates.

The networking approach that was built into the research design, enhanced rapport and trust between the researcher and the community and therefore, increased the chances of reaching social isolates. There is a strong confidence in the sample population as a result of the largeness of numbers included in the research. It is questionable at this time that another more statistically based sampling procedure would have yielded a larger and more representative sample frame than the sampling procedures utilized.

Perhaps a second potential source of limitation that confronted the research was the ability of the interview schedule to make a precise and culturally relevant

psychiatric case definition of mental illness in a valid and measurable form that could be considered applicable to Guamanian Americans in Northern California. The researcher acknowledges the fact that Guamanian culture and language are important elements that predispose them to have different perspectives on the etiology of mental illness. For example, in the Chamorro language (which is basically a concrete and nature-oriented language) there is no equivalent for the western concept expressed by anxiety.

Although the Chamorro language does permit for some abstraction, a great deal of experiences must be expressed by concrete, often physical statements and metaphors. A Guamanian American can be nervous (netbioso), but this is a description of physical trembling and not a psychological nameless dread. Often times, only one word can be used to describe both a physical and psychological entity. For example, the word "mind" and "brain" (teatanus) is the same. In the Chamorro language there is no distinction between the two. To overcome the discriptive limitation of the Chamorro language, Guamanian Americans would often incorporate the English word which could best communicate their thoughts, feelings, and meanings.

Although a case can be made against the appropriateness of using the interview schedule, it can also be defended from the point of view that Guamanian Americans

have had a long history of being associated with the Anglo culture and language. Therefore, the degree to which the interview schedule is congruent with some of the cultural peculiarities and attitudes of the Guamanian Americans does not totally invalidate the credibility of using the questionnaire for this research project.

The strength of the research lies in its ability to measure impairment as well as to compare the research findings with other projects that have utilized the same interview schedule. It should be noted that, to date, the interview schedule has been administered to White, Black, Asian, and Mexican American populations.

CHAPTER II

LITERATURE REVIEW

As immigrants, Guamanian Americans are newcomers to the United States and, as such, are probably one of the least known groups under the Pacific/Asian rubric. This may stem from their low visibility and from the lack of historical and census data on the one hand, and also from the fact that Pacific Islanders are generally given less attention and study than larger, more vocal and visible people of color, on the other.

Because of the limited amount of research devoted to the general conditions of Guamanian Americans in the United States, the review of the literature will examine related materials that are considered relevant and useful in understanding their mental health service needs.

Migration Patterns of Guamanian Americans

Woven into the mosaic pattern of Guamanian American migration is the basic question of "Why do people migrate?" In recent decades, different academic disciplines have attempted to answer this question within the confines of their conceptual orientation and tradition. These disciplines have variously developed and advocated the

Socio-Economic Push-Pull concept; the Psycho-Pathological concept; and the concept of Migration as a Fact of Life.

The Socio-Economic Push-Pull concept, with its inherent limitation (that is, oversimplification of the migration process), attempts to bridge a relationship between dissatisfaction with existing conditions and migration.

Historical studies of the vast migration that populated the American continent have pointed up, in a fairly general way, the great impetus to migration created by famine and disaster (push) or conversely, by available land and economic expansion (pull).[1] The most recent and vivid examples of the "Push-Pull" concept of migration occurred in 1975 and 1980, when 150,000 Indo-Chinese and 250,000 Cubans were "pushed and pulled" into the United States.

In further examining the Push-Pull concept of migration, Brody (1970), views mobility as:

> A shift in residents that not only involves new places, but new faces and new norms. Movement over distance implies the crossing of social system boundaries, whether the systems are deferred in terms of national entities, regional subculture or immediate friendship and kinship networks. The immigrant leaves behind the supports and stresses of the donor system including the push factors which contribute to the decision to move. He/she loses the support and values which were built while

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[1]Marc Fried, "Deprivation and Migration: Dilemmas of Causal Interpretation," in Behavior in New Environments: Adaptation of Migrant Population, ed. Eugene B. Brody (Beverly Hills, CA: Sage Publication, Inc., 1969).

> growing, and at the same time is freed of some of the threats of disease and hunger, of the obligation to perform in expected ways and of certain stressful relationships. The immigrant is excited by new stimuli and opportunities and fearful of new threats and the unknown.[2]

The Psycho-Pathological concept stresses the relationship between migration and mental illness. Early studies (Odegaar, 1932, and Malzberg, 1940) on the high hospitalization rates of immigrants stipulated three principles concerning the inter-relationship between migration and mental illness. They are: (1) that certain mental disorders incite their victims to migrate; (2) that the process of migration creates mental stressors which, in turn, precipitates mental disorders in susceptible individuals; and (3) that there is a non-essential association between migration and certain other predisposing or precipitating factors, such as age, social class, and culture conflict.[3]

According to Reul (1971), these theories and conclusions came about mainly because researchers studied highly mobile population groups in cities that have high incidence of unemployment, family breakdown, illegitimacy, delinquency, venereal diseases, mental illness, suicide,

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[2]Eugene B. Brody, ed.,"Migration and Adaptation: The Nature of the Problem," Behavior in New Environment: Adaptation of Migrant Population (Beverly Hills, CA: Sage Publication, Inc., 1969).

[3]H.B.M. Murphy, "Migration and the Major Mental Disorder," Mobility and Mental Health, ed. Mildred Kantor (Springfield, Ill.: Charles C. Thomas, 1969).

and crime. Since mobility seemed to be one consistent variable in all these groups, it was identified as the primary disorganizing factor.[4] Today, there is a tendency to regard the stress of migration experience as the most likely explanation, with selection playing a secondary role.[5]

The concept of migration, as a fact of life, presents an historical and present day perspective that mobility, whether it be voluntary or involuntary, is part of a world-wide process of urbanization and industrialization. Reul states, "We know today that the vast majority of the population of the United States has experienced at least one migration episode; larger numbers have experienced several."[6] It is unusual for an adult to be still living in the house in which he/she was born or even in the same neighborhood where he/she began school.[7]

Abroad, uprootedness is no longer a problem involving refugees alone, although refugees of the world can be counted in the millions. Families are moving by choice, by design, and because of changes over which they have no

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[4]Myrtle R. Reul, "Migration: The Confrontation of Opportunity and Trauma," Migration and Social Welfare, ed. Joseph W. Eaton (New York: National Association of Social Workers, Inc., 1971).

[5]Murphy, Mobility and Mental Health, p. 5.

[6]Reul, Migration and Social Welfare, p. 3.

[7]Bernard J. Friden and Robert Morries, eds., Urban Planning and Social Policy (New York: Basic Books, 1969).

control. Whole populations have experienced forced migration as a result of construction. In the United States, both urban renewal and highway constructions are common reasons for family relocation.[8]

In summary, the concepts presented view the migration saga as a powerful, continuous process and a fact of life that is as old as man's history. Although the three concepts provided different perspectives, they appear to share a common theme. That is, whatever the general or specific conditions for leaving, the migrating person is often motivated to seek a new environment that will enhance his/her opportunity structure and provide advantages lacking in their place of origin.

Guamanian Americans' migration experiences and patterns appear to fit well into the Social-Economic Push-Pull concept, as indicated in their desires and reasons for leaving Guam.

Munoz (1979), in her exploratory study of Guamanian migration patterns, provided some partial answers to why they left Guam. Her findings indicated that Guamanians migrated because of their general dissatisfaction with life on Guam; feelings of hopelessness and despair regarding the complexity of social problems and changes occurring on the Island; and feelings that the United

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[8]H. Eldredge Wentworth, ed., Taming Megatrapolis (New York: Basic Books, 1969).

States is a land of opportunity.[9] Furthermore, the urging of friends and relatives already in the United States contributed to their decision to leave.

Munoz's study also concerned itself with the description and analysis of three identifiable migration patterns of Guamanians to the United States, in particular to the Los Angeles area. The family migration groups identified were: (1) migration initiated because of military commitments; (2) migration initiated for the purpose of further education; and (3) migration to seek a new life in the United States.[10]

The settlement patterns of Guamanians, according to Munoz (1980) can be described as a function of the process of migration, the maintenance of the extended family system, and the formation of an adaptive mutual aid response to an urban industrial environment.[11] The strong and cohesive family structure among Guamanians and their close, cooperative social networks constitute the primary support system in the United States.

The family support system not only provides assistance in home finding and job referral, but also provides

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[9]Faye U. Munoz, "An Exploratory Study of Island Migration: Chamorros of Guam," (D.S.W. Dissertation, University of California at Los Angeles, 1979).

[10]Ibid.

[11]Faye U. Munoz, "Pacific Islanders: Life Patterns in a New Land," Asian Americans: Social and Psychological Perspective, Vol. II (Science and Behavior Books, Inc., 1980), pp. 141-154.

psycho-social security, initial guidance, and advice on how to survive in America. Their close social network and family structure enables them to maintain a community which remains invisible to the dominant society, yet clearly visible and powerful to maintain and sustain group life among Guamanians.[12]

Ishikawa's study (1979) on Guamanian elders revealed that the elderly helped others informally when resources and skills are at their command, but turn to their family system first when difficulties arise. Ishikawa describes this coping pattern as a function of two elements: (1) the search for and use of assistance that may be provided by the family members, and (2) the communication about the gathering of information, that is the information of social, fiscal, and supportive resources that may be mobilized.[13]

Migration and Mental Health

Migration is more than an act of moving from one location to another: it is an attempt to control one's destiny. There may be a need for a better job, more security, money, prestige, recognition, freedom, or a different way of life for oneself or one's family. It

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[12]Munoz, An Exploratory Study of Island Migration: Chamorros of Guam, p. 117.

[13]Wesley H. Ishikawa, The Elder Guamanian (The Center on Aging, San Diego: The Campanile Press, 1978).

may be the need for personal gratification or the need to be near relatives.[14]

In her essay, "Migration: The Confrontation of Opportunity and Trauma," Myrtle Ruel assumed that the migration process, regardless of the mover's class, culture, or reason for moving, is comprised of four stages, each involving specific psychological reactions: (1) making a decision; (2) breaking with the past; (3) the transitional period; and (4) the adjustment period.

The decision-making process often involves the family. This is true, even in those cases in which only one member is directly involved in the move. The family member with whom the idea originates may or may not be the decision maker. Therefore, until the actual decision maker hears the suggestion and accepts the plan, migration cannot take place.

In the second stage, the immigrant breaks with the past to plan for the future. Attempting to break away from the familiar and make the plunge into the unknown can be an anxiety producing process. How successfully he/she can break with the past and prepare realistically for the future will depend on many circumstances surrounding the move.

During the third stage, transition, the person is traveling to the new destination and having arrived, is

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[14]Ruel, Migration and Social Welfare, p. 6.

registering his/her first reactions to the new environment. At this stage, the immigrant still gives much thought to what was left behind and what is familiar. He/She has not yet become a part of the new environment and is between systems. Soon after arrival, he/she experiences culture shock in finding a different standard and style of living, different norms and values or perhaps a landscape or climate to which he/she is not accustomed. In addition to being temporarily rootless in a new environment, the immigrant is forced to come to terms with earlier hopes and expectations.

During the adjustment period, the immigrant will expend a great deal of psychic energy trying to bridge or ignore two uncomfortable gaps: the gap between what one is used to and what the new culture and environment presents and that between what was expected and what is, in fact, found to be the reality of the new environment. There is, of course, no clear line between the transitional period and the adjustment period in the migration episode. Adjustment occurs when the immigrant begins to recover from the initial shock of being in a new environment and proceeds with the long, hard, and purposeful task of becoming part of a new social system and its subsystem.[15]

Arkoff (1968) defines adjustments as a person's interaction with the environment. Each person constantly

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[15]Ibid., p. 15.

strives to meet his/her needs and reach his/her goals. At the same time, he/she is under pressure from the environment to behave in certain ways. Adjustments involve the reconciliation of personal and environmental demands.[16]

The degree to which Guamanian Americans have adjusted in the United States have yet to be thoroughly understood. However, if conclusions reached in other studies of families and immigrant families are valid and applied to the Guamanian Americans, it is assumed the traditional family structures and values insulate and protect the immigrant from negatively experiencing crisis, and contributes to the general well-being of its members.

Hill (1958) found that family adaptability, integration, affectional relationship among family members, good marital adjustment, companionable parent-child relationships, and so forth, are all important factors in enabling families to adjust to crisis.[17]

Generally, the Guamanian American family is a close knit and extended system, with a feeling of responsibility, care, and support for all their members. However, as the traditional Guamanian American family becomes assimilated into the dominant culture of their new environment, one can predict that the family's ability to cope with crisis

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[16]Abe Arkoff, Adjustment and Mental Health (New York: McGraw-Hill Book Co., 1968).

[17]Reubin Hill, "Social Stresses on the Family," Social Casework, Vol. 39. (1958), pp. 139-150.

and adjustment problems will be weakened and there may be a corresponding increase in mental health related problems.

CHAPTER III

HISTORICAL BACKGROUND OF GUAMANIAN AMERICANS

To better understand the Guamanian American community in the United States today, it is essential to present a brief social historical background of the people of Guam.

The Island of Guam

Guam, with a population nearing 115,000, is an unincorporated territory of the United States. It is the largest island in the Marianas and is located in the Northern Pacific Ocean between Hawaii and the Philippines and between Japan and New Guinea. The Island measures approximately 225 square miles and is about 30 miles long and four to nine miles wide.[1] In terms of distance and air travel, Guam is 3,300 miles or seven hours from Hawaii and 5,500 miles or twelve hours from San Francisco.

The weather on Guam is generally warm and humid, with an average yearly temperature of 80 degrees Fahrenheit. Guam has a "dry season" from January to June and a "rainy season" from July to December, with an average rainfall of 90 inches. Located in the "typhoon belt" in the

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[1]Paul Carano and Pedro C. Sanchez, A Complete History of Guam (Charles E. Tuttle Co., Inc., 1964).

Fig. 1. General Locator Map of Guam

SOURCE: U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, Vol. 1, Parts 54-58.

Pacific, Guam is sometimes hit by violent typhoons whose high velocity winds cause considerable destruction of property and loss of life. Two of the worst typhoons in the past two decades were Typhoon Karen in 1962 and Typhoon Pamela in 1976.

The Ancient Chamorro Era

The remote ancestors of the present day Guamanian Americans were called Chamorros. It is speculated that the Chamorro people were of Malaysian stock that migrated from Southeast Asia in 1500 B.C.

The ancient Chamorros, according to early reports, were tall, robust, well-built, brown-skinned, and apparently of great strength. The women, too, were tall, "good looking," delicately formed, lighter complexioned than the men, and wore their hair loose and flowing to the ground. According to all accounts, Chamorro men wore no clothing, while Chamorro women wore a cord tied about their waist, from which they hung some grass or leaves from trees. Others wore little aprons or mats made from palm leaves.[2] Regarding their temperament, the ancient Chamorros were described as being playful and friendly, although they could be stubborn and violent when sufficiently provoked.

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[2]Emma Blair and James A. Robertson, The Phillipine Island, 1493-1898, Vol. II (Cleveland: Arthur H. Clark Co., 1903).

Chamorro society was based on a strict caste system which consisted of the Upper Class or Matua, the Middle Class or Atchaot, and the Lower Class or Manachang. The highest ranking nobles or chiefs called themselves "Chamorri." According to Carano and Sanchez (1964), the Matua had the most privileges; were principle landowners and controlled most of the wealth of the island. Occupations having the highest privileges were reserved for them exclusively.

The Atchaot, consisted of lesser nobility and they were usually members of the family or near relatives of the Matua and were permitted to assist the Matua in their occupation of honor. The Manachang lived almost as slaves. They were set apart from the rest of the society and their lives were completely governed by restrictions and taboos.[3]

Chamorro society was organized into matrilineal clans, where the women exercised great influence in all matters related to family life, property, and inheritance. Moreover, the children took the surnames of their mothers, rather than of their fathers.[4] This system was abolished by the Americans. Now the children are required to carry the names of their fathers. The ancient Chamorro religion had no organized priesthood, no temples, and no definite

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[3]Carano and Sanchez, A Complete History of Guam, p. 14.

[4]Laura Thompson, Guam and Its People: A Study of Culture Change and Colonial Education (Princeton, N.J.: Princeton University Press, 1947).

creed. It seemed, primarily, to be a religion based on myth, superstition, and ancestor worship. They had a class of professional sorcerers called Makahna and Kkahna, who practiced some form of magic. Another group, called Suruhana, were herb doctors. These herbalists continue to practice their craft today.

The Chamorro-Spanish Era (1521-1898)

During his historic circumnavigation of the world, Ferdinand Magellan landed on Guam in 1521. Because of its location, Guam became an important port-of-call for many such early voyagers. From the initial contact and for approximately 150 years thereafter, Chamorro culture remained relatively unchanged. According to Thompson (1941), the clash with western civilization began in 1668, when a band of Spanish Jesuits and soldiers founded the first Christian mission on the island.[5] At first, the missionaries were well received, but when they attempted to suppress native customs, they were met with staunch resistance.

This marked the beginning of the Chamorro/Spanish War, which lasted for twenty-five years. By the end of the war, the Chamorro population of approximately 100,000 was almost totally annihilated and was reduced to a mere 5,000. Most of the survivors of the Chamorro/Spanish War

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[5]Ibid., p. 31.

were women and children. The remaining Chamorros established liaison with the Spanish, Filipinos, and others for the next two centuries that resulted in the present population/culture of Guam. Only the Chamorro language, with its strong Spanish influence, survived as an integrated, functioning link between the old and the new. The culture of the present day Guamanian Americans reflects the long period of Spanish influence, especially the influences of the Catholic Church.

The Guamanian-American Era (1898-1982)

In 1898, the United States took possession of Guam as a result of the Spanish-American War. Guam was "captured" without any military resistance from the Spanish garrison stationed on the island. This was possible because it appears that, in addition to not having adequate military strength to defend the island, the Spanish Governor on Guam did not know that Spain was at war with the United States and did not resist the American occupation forces.

The responsibility for managing the affairs of the island was designated to the Department of the Navy as a temporary expedient, until the Congress of the United States could determine the island's political status. Under the naval government, the entire island was declared a naval station, governed by a naval officer who was appointed by the Secretary of the Navy to serve a two

year term as Governor. The naval government continued, with the exception of the period of Japanese occupation (1941-1944), until the passage of the Organic Act of Guam in 1950.

The Organic Act granted the people of Guam United States citizenship and defined Guam's political status as an unincorporated territory of the United States. This Act additionally established a civil government, created a legislature with full lawmaking powers, and established a District Court of Guam, thereby ending almost 300 years of colonial military government. Two decades after the passage of the Organic Act, the people of Guam were given the right to elect their own Governor and a non-voting Delegate to the United States House of Representatives. The privilege of electing their own political leaders has had some social and familial drawbacks. As people formed political alliances, they also created factions among themselves. Conflicts between the desire to assert themselves and their cultural values of togetherness and harmony often clashed.

Regarding the early influences of Spain and the United States, Thompson (1941) writes:

> The basic Chamorro-Spanish configuration of culture, centering in home and Church, which was developed in Guam over a period of centuries, contrasted strongly with certain aspects of the recently introduced American patterns of thoughts and behaviors which on Guam, bears chiefly on government and economics. On one hand, there is the well-integrated Catholic Chamorro pattern of static absolute values, strict

> discipline, and regimentation, and on the other a growing complex of confusing traits from America which presents a striking contrast in fact, namely the military rule and in theory, namely the dynamic democratic ideals, belief in the sanctity of the individual and his fundamental right to spiritual freedom and equality of opportunity.[6]

The American government, unlike their Spanish predecessors, who sought economic development and wealth through the acquisition of land and souls, were primarily more interested in acquiring land, but not souls. In Guam's case, the island, because of its strategic location, became one of America's most important bastions for defense in the Western Pacific.

During the early period of naval government, the people were introduced to compulsory education and to American ideals. American education, like religion during the Spanish times, became the vehicle by which the Chamorros became Americanized. The policies of the naval official, according to Agoun (1979), left a legacy of self-doubt and self-denial among the people, which they still face today. Frequently, the Governor's reports to the Secretary of the Navy measured educational progress, not in terms of English acquisition, but rather in terms of how little Chamorro was being used in some homes.[7]

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[6]Ibid., p. 67.

[7]Katherine B. Agoun, "The Guam Dilemma: The Need for a Pacific Island Education Perspective," Amerasia, 6:2 (1979), pp. 77-90.

In keeping with the educational policies of the naval government, the curriculum used in Guam were transplanted from the California and New Mexico educational systems with slight modification. Agoun (1979) states:

> The most damaging effect of education during this period was not the direct cultural abuse endured or the political rights ignored; rather, it was the psychological internalization of the Navy's image of Chamorros by Chamorros themselves. Told that they were lazy, incompetent, and part of a primitive reality, the people eventually accepted these distorted images. Chamorros became their own worst enemy in terms of self-concept.[8]

The development of the island, as a major United States military base in the Pacific and its reconstruction, caused serious and significant changes in the lives of the Chamorros. These changes included a new economic lifestyle, where the islanders began working for wages rather than continuing with their previous agrarian barter economy. Family ownership of land was curtailed and secured for military and government activities, causing the kinship/clan structure to become separated and disorganized.

On December 8, 1941, the island was attacked by the Imperial Forces of Japan. Three days later, the island surrendered to the invading Japanese and this marked the beginning of 31 months of iron-fisted rule. During the Japanese occupation, the Guamanians were governed by new sets of laws that denied individual freedom and liberty.

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[8]Ibid., p. 83.

Although "fair" treatment was publicly proclaimed by the Japanese, Guamanians were subjected to acts of brutality and indignities of the worst sort. The experiences of the islanders during the Japanese occupation only enhanced their desire to have the Americans return and to become a part of the United States.

On July 21, 1944, the island was recaptured by the United States. This date is officially designated as "Liberation Day" and is annually celebrated by the entire island, as well as Guamanian Americans in California. According to Munoz (1979), the need for manpower in military activities forced people to work as part of the labor force. Wartime survival needs superceded the usual family concern over land and farms. People saw the war as a crisis which would eventually be overcome. They believed that things would be able to return to their former lifestyle. This has not proven to be the case.[9]

Although the social order, after the Japanese occupation ended, did not return to former values, the people were so grateful for once again being liberated, that they gave unquestionably their political loyalty to the United States. The end of World War II wrought rapid changes in the traditional lifestyle of the people. Traditional island life began to give way to American ideals and

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[9]Faye U. Munoz, "An Exploratory Study of Island Migration: Chamorros of Guam," (D.S.W. Dissertation, University of California, Los Angeles, 1979).

material technology. This trend continues to the present. The Americanization of the island can be said to be successful in light of the rapid deterioration of traditional values and behaviors of present day Guamanian Americans.

Metaphorically, the consequences of acculturation and social changes can be related as symptoms of "growing pains," associated with the process of Americanization. But when one looks closer at the history of the islanders, it may be more appropriate to metaphorically describe the current situation as symptoms of "labor pains." It is without question that Guam is undergoing dramatic and painful changes, where people are grappling with the changes in order to have some control over their lives and destiny.

The metaphor, "labor pains," describes a developmental and transitional period of uncertainty, struggle, stress, and strain for the Islanders. This situation can best be described with the generation gap between traditional values versus new patterns of thoughts and behaviors. Generally, the younger generation views traditional values and behaviors as "old fashioned"--having limited utility in their lives. For example, in the traditional Chamorro culture, interdependence, respect for nature, the supremacy of familial obligations, respect for old age, and respect for social position were highly valued. While individual responsibility existed, the need for

individuality was deemed insignificant when compared to social and familial obligations.

In the past, reliance and interdependence on the family system was very important to the overall economic and psychosocial well-being of the kinship members. In recent times, traditional Guamanian American values and authority have been diffused as a result of new educational programs, conversion to a cash economy (from a subsistence agriculture economy), increasing demands for imported convenience goods, and exposure to other values and customs through the media, tourists, and returning relatives. As a result, there are new challenges arising from the increased formation of nuclear families and values emphasizing individual achievement and thereby weakening the authority of the extended family. Many of the younger generation are becoming more independent of the family system, as well as unrestrained by traditional social/cultural mores and values.

Although traditional values and authority, such as those mentioned earlier, are being challenged and diffused by the younger generations, it should be noted that such values are still very evident in today's Guamanian American society. However, the difference between the Islanders of today and those of the past (in terms of cultural values) lies in the fact that the younger generations have more options and opportunities for greater

individual freedom of choice of values and life styles one can have.

The brief historical overview presented a chain of events that have occurred in Guam since pre-western contact. It provided a glimpse of how we have been colonized by world powers. However, it lacked a necessary ingredient of how history has affected the Islanders. In other words, what price did the Chamorro people pay for their present life style? It is the researcher's opinion that external forces and influences have had both a positive and negative impact on the people of Guam. Guam can be said to have all the modern conveniences comparable to the mainland United States. Our standard of living has certainly improved in terms of material advancement, however, not without intangible costs to our culture and society. In the past two decades, significant individual and social problems are becoming more apparent as the true cost of societal modernization and development in Guam.

There is a widespread awareness among Guamanian Americans of the problems caused by rapid social/cultural changes that are beyond their control. Quite often one will hear local people making statements, to the effect, that life in the past was much better than it is today because of all the social problems occurring in modern day Guam.

From the researcher's perspective, mental health on Guam involves a wide range of issues and problems that are not only limited to the traditional modus operandi of mental health delivery systems. For example, on Guam violent crimes and heroin addiction--a gift of the Vietnam War--have been a major problem among adolescents and young adults. Although Guam, in the past, was not necessary a crime free society, violent criminal activities related to drug abuse was non-existent prior to the onset of the Vietnam War.

It is the researcher's opinion that these problems (violent crimes and drug abuse) are the hidden prices that we Guamanian Americans are paying for modernization. There is little speculation necessary to know that Guamanian Americans in the process of further development towards western ideas and behaviors will continuely be faced with personal and social problems. Therefore, the need for treatment and prevention of mental illness will become more acute.

C H A P T E R I V

RESEARCH DESIGN AND METHODOLOGY

The research design called for the identification of mental health service needs by means of psychiatric symptom and dysfunction scale scores. Furthermore, the research examined the samples' utilization of formal and informal resources and potential barriers to the utilization of mental health services.

Community Contacts

It was considered essential to the success of the research to secure the support and cooperation of the Guamanian American Community. The researcher had to be recognized and accepted as an insider and a contributor to the general well-being of the community.

To increase the likelihood of community acceptance, five tasks had to be accomplished before starting the interviews. First, personal contacts were made with the presidents of Guamanian clubs, and a follow-up meeting was held with their general membership during one of their monthly club meetings. Second, press releases providing information about the research were distributed during all club meetings and social gatherings (see Appendix A).

Each Guamanian club was given extra flyers to pass out to relatives and friends who are not members of any Guamanian club. Third, personal letters were mailed to every Guamanian household that was identified (see Appendix B). Fourth, a community advisory committee was formed, which consisted of four club presidents and one key informant who is well liked and respected by members of the Guamanian American community. Fifth, the researcher attempted to become visible and approachable to the community by attending as many social functions as possible within the Guamanian American communities.

In each of the community contacts, a concerted effort was made to explain the nature, purpose, and possible benefits to be derived from the research. The Guamanian American communities in the research site are quite small with an effective and efficient informal word of mouth communication network called Tellefon Alaijai that keeps its members informed of what is happening within the community. If the research had been getting bad press, the community would not have continued to cooperate.

Sample Selection

The research sample consisted of 548 Guamanian Americans over the age of eighteen living in Santa Clara, Alameda, and Solano counties. The sampling procedures employed generated a purposive (snow ball) rather than a statistically proportionate sample.

This method of sampling was used to circumvent a major problem of not having reliable census data on the Guamanian Americans. Furthermore, the research sites have a large population of people with Spanish surnames similar to the Guamanian Americans. This situation precluded using conventional means of identification, such as electrical utility listings or telephone directories.

Initial selection was, therefore, based on lists of potential respondents obtained from several sources. In many instances, this meant that the initial selection included a number of persons who formally belonged to Guam clubs. From that point, allowance was made for individuals to be included in the research by referrals from some of the respondents themselves, as well as from other community persons.

Six hundred seventy-five (675) personally addressed letters were mailed to persons on the master list of which seventy-seven (11.7 percent) were returned because of a change of address. Of the total number of individuals contacted by mail, 548 (91.6 percent) were successfully interviewed. The major source of non-response consisted of the following: Refusal--33 (5.5 percent); Not able to contact respondents after a minimum of five calls--7 (1.1 percent); Phone numbers not available--10 (1.6 percent).

Interviewer Selection, Training, and Supervision

The community contacts helped in identifying potential interviewers. Each interviewer was screened and selected on the basis of their ability to speak fluent Chamorro and English, ability to establish rapport easily, ability to participate without any strong biases, and willingness to devote evenings and weekends to the research.

Training of the interviewers took twelve hours. Each interviewer attended a four hour general session and an eight hour laboratory session. During the general session, the nature, purpose, and interview techniques and procedures were presented. Issues concerning potential problems and the Chamorro culture were covered with emphasis on humanizing the interview process.

Prior to commencing the laboratory sessions, each interviewer was required to practice interviewing family members or friends at least two times in order to gain familiarity with the interview schedule and its skip patterns. The laboratory session provided each interviewer the opportunity to role play and practice interviewing the researcher over the telephone. During the role playing sessions each interviewer was exposed to a variety of possible responses and questions that could occur during the actual interviews. After each role playing, a debriefing session was conducted for the purpose of

processing the role playing experience. Throughout the training, the interviewers were encouraged to proceed with their own natural style and be comfortable with the interviews.

The first two interviews were made a part of the training process and all interviewers were again debriefed intensively in order to identify any major problem encountered by them and to reinforce the positive aspects of their experience. The debriefing period also served as an evaluation of each interviewer's level of readiness to commence interviewing on their own. The overall training intent was to free the interviewers to augment their own natural and culturally appropriate capabilities while at the same time furnishing them with the necessary data collection and recording techniques. Each of the interviewers was provided with the following materials: (1) questionnaires; (2) an alphabetical listing of names of people to be interviewed; (3) a standard introductory and closing statements guide; (4) a fact sheet; and (5) a daily work sheet.

The researcher provided daily supervision; assigned cases; collected, edited, and kept records of each interview; checked each completed interview schedule for detail and thoroughness; verified interviews on a random basis; and conducted daily staff meetings to discuss progress and problems encountered during the day.

Interview Procedures

Every household on the master list was verified to ensure that the names and telephone numbers are correct and that they are Guamanian Americans. Directory assistance was requested to verify listed telephone numbers. Unlisted numbers were called directly in order to verify the needed information. Once the master list had been verified and updated, it was separated into four alphabetical sections and each interviewer was assigned to cover a section.

One week prior to starting the interviews, personal letters were sent to potential respondents informing them of the research and requested their cooperation. After an interview was successfully completed, a letter of appreciation was sent to each participant (see Appendix C). All of the interviews were conducted over the telephone, seven days a week between the hours of 1:00 p.m. and 9:00 p.m. Once a potential respondent was contacted, the interviewer read a standard introductory statement and asked permission to conduct the interview either immediately or by setting an appointment at a later date (see Appendix D).

The average length of the interviews were approximately thirty-five minutes which was determined in part by the conversational customs of Guamanian Americans. Once the inteviews were completed they went through five discrete processing steps:

1. Quality Control--Each interview schedule was inspected to make certain that it was completely filled out and that responses were not ambiguous and additionally that all written information was legible.

2. Editing--Response patterns were checked for inconsistent or impossible entries and for ambiguous responses.

3. Coding--All responses were coded on the interview schedule and were made compatible with the Statistical Package for Social Science (SPSS) computer data processing format.

4. Key Punching--Completed interview schedules were key punched and verified by trained and experienced key punch operators.

If problems were found, they were referred to the interviewers for clarification. However, if the discrepancies could not be resolved between the researcher and the interviewers, the respondents were contacted again for verification of the response.

Interview Schedule

The interview schedule utilized was designed and constructed by Dr. George Warheit, et al., during a major epidemiologic field survey in Florida.[1] The interview

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[1]Schwab et al., Social Order and Mental Health: The Florida Health Study, (Brunner/Mazel, Inc., 1979).

schedule took more than a year to complete and involved analyzing a large number of interview instruments, questionnaires, patient data forms, and related materials from earlier research efforts.

In its final form, the original interview schedule consisted of 317 separate items, many of which had multiple parts. The interview schedule for this research was a shorter version of the original interview schedule, and consisted of ninety-three questions (see Appendix E). The interview schedule was constructed so that its sub-components were dynamically interrelated, that is, a conscious effort was made to give the interview schedule a systemic active interrelatedness. Ten mini pretests were conducted before finalizing the interview schedule in order to identify any problems in the wording or structure and to establish the average time to complete the interviews.

The interview schedule included an extensive inventory of items, scales, and indicies designed to obtain the following information:

1. Social and demographic characteristics of each respondent.

2. Patterns of social and interpersonal interactions between respondents and their family system and friendship networks.

3. A physical health system review.

4. A comprehensive mental health inventory related to a broad spectrum of psychiatric symptoms, syndromes, and related dysfunctions.

5. A health service utilization inventory.

6. Mental health help seeking behavioral patterns of the respondents.

7. Barriers to mental health services.

As a composite, these items secure data on each respondent's mental and physical health, coping resources, social functioning, and interpersonal well-being.

Prior to administering the interview schedule, it was anticipated that some categories of questions might raise a certain amount of resistance on the part of the respondents, while other questions would prove more neutral. Therefore, questions belonging to different categories and representing different levels of sensitivity were ordered in a sequence ranging from the general and impersonal to the specific and personal. In this way it was hoped that the interviewers would have established a good measure of rapport with the respondents before sensitive areas were touched upon. The interview schedule falls short of directly asking the respondents, "What are your problems or needs?"

This approach and knowing the potential adverse reactions of the respondents would not have yielded helpful responses. Furthermore, it was felt that in addition to

the sequencing patterns of the questions (general and impersonal to specific and personal), the use of indirect social indicator questions were equally capable of obtaining as much information as the direct approach and it is far less likely to offend the respondents. To minimize further the potential resistance of the respondents, it was stressed that the interview schedule would be used only in aggregate form and that strict confidentiality would be maintained. The anticipated resistance on the part of the respondents was not a major problem since it never materialized.

The mental health component of the interview schedule was based on epidemiologic literature and from clinical experiences that were tested for reliability by means of Cronbach's Alpha and were found to have a Coefficient of Reliability above .80. The test for Construct Validity included rating made by three psychiatrists and scale scores comparison between patients and non-patients.[2]

Data Analysis

Once the information from the interview was collected, verified, and coded, an analysis of the data to determine the mental health service needs of Guamanian Americans was

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[2]George J. Warheit, "An Assessment of Need for Mental Health and Alcohol Related Services in the State of California." Gainesville, Florida: June 30, 1980.

carried out by the use of a statistical normative technique. This technique was applied to the data which helped to establish scores on five scales designed to measure psychiatric symptomatology and psychosocial functioning. The scales that were selected from Warheit's inventory address the following general areas: (1) Depression, (2) Anxiety, (3) Psychosocial Dysfunction, (4) General Psychopathology, and (5) Cognitive Impairment.[3]

The first step in identifying the various mental health service need categories consisted of computing overall mean scores for the 548 respondents for each of the five scales in order to establish norms. Cut off points were then established at one standard deviation above the mean.

The second step in establishing a need rate for mental health services was accomplished by summing the number of scales on which each respondent scored one or more standard deviation above the mean. Once standard deviations were computed for the entire sample, the population was divided into several categories.

Respondents whose scores on all symptom and dysfunction scales were below one standard deviation above the mean were defined as being in the normal range. Those whose scores ranged from one or more deviation above the mean on one or two of the scales were identified as

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[3]Ibid., pp. III-9.

being at low risk. Next, those with scores one or more standard deviations above the mean for three or four of the scales were identified as being in the moderate risk category. Those scoring one or more standard deviations above the mean on all five measures were defined as being at high risk for mental health problems.

Given the inherent difficulties in making a precise case definition or identification of needers and non-needers of mental health services in the general population, the extrapolation procedures outlined above is a sound one and can be justified on several grounds.[4]

1. Most simply, it is logical to assume that those with the highest symptom and dysfunction levels among the general population are likely to be those with the highest need.

2. The design provided a sample which approaches that of the general Guamanian American population.

3. The scales used for making the estimates regarding the need for types of services were tested extensively for reliability and validity.

4. These validity studies included extensive work with known patient groups.

5. The risk rates utilized in part to establish the validity of the various scales included factors known to

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[4]Ibid., pp. I-11, 12.

predispose persons to the need for varying types of mental health services.

6. The scales which were tested for appropriateness by a variety of methods over a period of years have generated findings that are generally consistent with a large body of epidemiologic and clinical literature.

CHAPTER V

THE SETTING

This chapter provides an overview of the geography, population, economy, and county community mental health system of the research setting. Awareness of the physical, economic, and mental health service characteristics of the setting are necessary in order to put into context the anticipated mental health service needs of the Guamanian American respondents.

County Profiles

Santa Clara County. Santa Clara is located in west central California at the south end of San Francisco Bay. The county is an irregularly shaped area of 1,321 square miles. Approximately one third of this area is relatively flat with few topographic barriers. The remaining area is rough terrain--the Diablo Range and the Santa Cruz Mountains along the eastern and western boundaries of the county.[1]

The Santa Clara Valley stretches across the sixty mile length of the county and varies in width from five

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[1]Santa Clara County Planning Department. A Study of the Economy of Santa Clara County, Part I. (San Jose, CA: Santa Clara County Planning Department, 1967).

miles in the south to fifteen miles in the north. Most of the urban development is on the valley floor.[2] Adjoining counties are San Mateo on the northwest, Santa Cruz on the west, Merced and Stanilaus on the east, and Alameda on the north.

The county's climate is mild year around with mean temperatures seldom falling below forty degrees in the winter or rising above eighty degrees in the summer.[3] The seasonal distribution of rainfall follows the Pacific Coast pattern--wet winters and dry summers. This favorable climate remains an important factor in the valley's development which has fostered a rich fruit and vegetable industry as well as attracting other types of industry, such as electronics and high technology based manufacturing.

Today Santa Clara County's economy is largely dependent upon manufacturing. However, prior to 1940, the county was primarily rural and agricultural. At the turn of the century, approximately 100,000 acres were planted with fruit trees and food processing became the first major manufacturing industry. During the late 1940's and through the 1950's, the county's economic base

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[2]"Answer Book and Almanac: Santa Clara County, 1982 Edition," The Mercury News, 20 September 1981, Milpitas, California.

[3]U.S. Department of Commerce Weather Bureau, Climatological Summary.

shifted from agriculture, trade, and services to manufacturing. The decade 1950-1960 marked the county's most spectacular period of growth, and highly diversified industries created employment opportunities which led to rapid population growth and the present fragmented urban-suburban land use pattern.

By 1946 the electronics industry, in terms of employment, had become the dominant industry in the county. The industry moved rapidly from manufacture of vacuum tubes to the manufacture of transistor for integrated circuitry, and more recently to the silicon chip.[4]

With a population of 1,295,071, Santa Clara County has the largest population of all the Bay Area counties.[5] About 22 percent of the people reside in the northern section of the county, 26 percent in the central portion of the county, and 4 percent in the southern section of the county.[6] According to the 1980 U.S. Census, there are 1,037 Guamanian Americans residing in Santa Clara County.[7]

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[4]Santa Clara County Planning Department. A Study of the Economy of Santa Clara County, California, Part I.

[5]U.S. Department of Commerce, Bureau of the Census, 1980 Census of Total Population, United States, California, San Francisco Bay Area, and other Selected Counties. (Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, May 1981).

[6]Santa Clara County Health Systems Agency. Health Systems Plan, 1981-1985, Vol. I. (San Jose, CA: Santa Clara County Health System Agency, 1981).

[7]State Census Data Center, Population Research Unit, Department of Finance: U.S. Census Bureau, December 1981. Asians in the United States, California Bay Area.

However, the Federation of Guamanian Association of America provides a higher figure of 5,000 Guamanian Americans in Santa Clara County.[8]

Alameda County. Alameda County extends thirty-five miles from the eastern shore of San Francisco Bay and occupies a land area of 7,333 square miles. Its topography is diverse, ranging from flat lands along the Bay to rolling hills that move eastward towards the central coast mountains. Climate conditions vary considerably within the county. Moderate year-round temperatures near the Bay contrast with hot summers in the eastern part of the county.

Historically, the economy of the county gradually shifted from an agricultural base throughout the nineteenth century to industry and services in the first half of the twentieth century. The county's economic base is comparatively large and diverse. It is an important center for manufacturing, transportation, wholesale trade, education, and military installations.

Several permanent government military facilities contribute substantially to Alameda County's economy. These include the Alameda Naval Air Station and the Oakland

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[8]The Federation of Guamanian Associations of America, "Estimate of Guamanian Population in California, as of October 18, 1978," in Pacific Islander Health and Health Care Workshop Final Report, Center for South Pacific Studies, University of California, January 13-14, 1979.

Army Base. Also, the University of California at Berkeley which provides employment for more than 18,000 professional and service personnel is a distinctive feature of Alameda County's economy and one of the primary factors in its economic growth.[9]

With a population of 1,105,379 Alameda County ranks second behind Santa Clara County among the nine Bay Area counties.[10] The 1980 Census reports that there are 1,734 Guamanian Americans residing in Alameda County.[11] In contrast, the Federation of Guamanian Associations of America estimates that there are approximately 4,500 Guamanian Americans in this county.[12]

Solano County. Solano County, which is one of the nine counties considered part of the San Francisco Bay region, is located halfway between the San Francisco and Sacramento metropolitan area. The gross area of the

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[9]Security Pacific Bank, Research Department Monthly Summary of Business Conditions, Northern Coastal Counties of California, Vol. 11, No. 4. (San Francisco, CA: Research Department, Security Pacific Bank, April 30, 1979).

[10]U.S. Department of Commerce, Bureau of the Census, 1980 Census of Total Population, United States, California, San Francisco Bay Area, and other Selected Counties.

[11]State Census Data Center, Population Research Unit, Department of Finance: U.S. Census Bureau, December 1981. Asians in the United States, California Bay Area.

[12]The Federation of Guamanian Associations of America, "Estimate of Guamanian Population in California, as of October 18, 1978."

county is 898 square miles composed of 823 square miles of land and seventy-five square miles of water.

Water areas include San Pablo Bay, the Mare Island Strait, Suisun Bay, the Sacramento River, and related sloughs. The western quarter extends into the coastal range foothills, characterized by steep slopers becoming more gently rolling in the easterly portion. The remainder of the county is part of the Sacramento Valley Basin, except for isolated areas of low rolling hills. Other features include the Suisun Marsh with an area of more than eighty square miles and the Napa Marsh. Solano County has mild climate throughout the year with lows in the thirties and highs in the nineties.[13]

The economic structure of Solano reflects the impact of defense installations. Agriculture, however, still exerts a powerful influence on the economy and much of the county's manufacturing activity is directly related to the processing of agricultural commodities.

Growth in income and population over the years has induced expansion of the trade and service industries in the county.[14] The federal government through the Naval

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[13]Solano County Planning Department. (Fairfield, CA: Solano County Planning Department, 1980).

[14]Bank of America National Trust and Savings Association. Focus on Napa and Solano Counties: An Economic Study of Vallejo-Napa Metropolitan Area (Bank of America NT & SA, February, 1966).

Shipyard at Mare Island and Travis Air Force Base contributes significantly to the county's economic base. Several state institutions also contribute to the economy and employment. The largest of these is the Napa State Hospital, the Veterans' Home, and the California Medical Facility. Agriculture is the most important non-government basic industry in the county today as it was in 1940, although jobs in agriculture have declined in proportion to total employment.

Since 1940 Solano County has seen rapid population growth. Increased employment in military establishments and agriculture provided the basis for a population increase from 204,885 in 1970 to 299,827 in 1980.[15] Most of the people are concentrated in the western part of the Vallejo Fairfield Napa Standard Metropolitan Statistical Area.[16] The 1980 Census reports that there are 1,422 Guamanian Americans in the Solano County,[17]

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[15]U.S. Department of Commerce. Bureau of the Census, 1980 Census of Total Population, United States, California, San Francisco Bay Area, and other Selected Counties.

[16]California Almanac. California Yearbook, Bicentennial Edition, (California Almanac Company, September, 1975).

[17]State Census Data Center, Population Research Unit, Department of Finance: U.S. Census Bureau, December 1981. Asians in the United States, California Bay Area.

while the Federation of Guamanian Associations reports a larger figure of 5,000.[18]

County Community Mental Health System

The counties of Santa Clara, Alameda, and Solano health departments, like all health departments in California, are built on the foundation of constitutional law. Upon this foundation, the sovereign state of California has provided enabling legislation that delegates local jurisdictions the authority and responsibility of protecting and promoting the mental health of its citizens.

The core of the California systems for care and treatment of the mentally ill have been affected by two important laws, the Short-Doyle Act and the Lantern-Petris-Short Act. The Short-Doyle Act, which was passed in 1956, mandates provisions of locally controlled health services by counties with 100,000 population and provides partial (now up to 90 percent) state reimbursement for such services.

The Lanterman-Petris-Short Act, passed in 1968, spells out the rights of patients who have been involuntarily committed. The Lantern-Petris-Short Act is primarily concerned with the scope and nature of the involuntary

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[18]The Federation of Guamanian Associations of America, "Estimate of Guamanian Population in California, as of October 18, 1978."

treatment modalities used on mentally disordered persons, alcoholics, and users of narcotics and restricted substances. Furthermore, this act developed a single system of care that coordinates all mental health services provided by state hospitals, local government, and private agencies. The services included under the Short-Doyle Act are:

(1) Inpatient Services (not limited to hospital-based care), including diagnosis, evaluation, and treatment such as individual, group, and family therapy and medication
(2) Outpatient Services, including evaluation, diagnosis, and treatment such as individual, group, and family therapy and medication
(3) Partial Hospitalization Services, which may include evening care, night care, or weekend care, as well as day care
(4) Emergency Services
(5) Consultation, Education, and Information Services
(6) Diagnostic Services
(7) Rehabilitative Services
(8) Pre-Care and After-Care Services
(9) Training for Staff
(10) Research and Evaluation.[19]

In addition to and in support of state and county operated mental health services and programs, each county contracts non-profit community-base organizations.

The California State Plan for Community Mental Health Centers has designated features of community mental health programs which has served as local guidelines for mental health services. The guidelines are as follows:

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[19]California Office of Statewide Health Planning and Development, Preliminary California State Health Plan, 1980.

(1) Mentally ill people will be treated near home by a local mental health program
(2) Treatment will be on a voluntary basis, wherever possible
(3) Patients will be referred and admitted to a state mental hospital for inpatient treatment only if the local mental health program determines that the individual has a mental disorder and requires 24-hour hospital care and that such care is not available locally. The state hospital will operate in support of the local programs
(4) Upon release from state hospitals, patients will be referred back to the local program for after-care, as needed
(5) All Californians will be eligible for mental health services regardless of their economic or ethnic status
(6) Services will, to the extent possible, be tailored to the needs of the patients, with emphasis on minimum institutionalization
(7) All publically financed mental health services will be integrated into a single delivery system toward the goal of reaching maximum effectiveness and minimum duplication.[20]

Santa Clara County Mental Health System. The County of Santa Clara has eight Community Mental Health Centers, each serving a geographical area of the county ranging from Palo Alto to Gilroy. Community service programs within each of the eight Community Mental Health Centers serve a wide variety of target groups, i.e. gays, handicapped, ethnic minorities, battered women, geriatrics, general population, penal offenders, chronics, schools, etc. Within the Mental Health Bureau are three programs that provide community services to special target areas They are:

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[20]State of California. California State Plan for Community Mental Health Centers. (Sacramento, CA).

(1) Mental Health Guidance Unit at Juvenile Probation Department. This unit is involved in a number of community services, e.g., consultation to the juvenile court, the Children's Shelter and three juvenile ranches, consultation to probation officers at Juvenile Probation Department, etc.
(2) Main Jail Consultation Program. This unit consults with the entire spectrum of legal entities, primarily around mental health issues as they relate to the mentally ill criminal offender who is in custody
(3) Community Services Unit to Care-Givers of Chronic Clients. The unit's primary mission is to maximize the services provided by all care-givers for chronic clients in the Downtown Mental Health Center's geographic area of responsibility, and by residential care facilities throughout Santa Clara County.[21]

The Santa Clara County Mental Health Bureau also has contracts with three non-county agencies to provide community services. These are:

(1) Asian Americans for Community Involvement (AACI). The objectives of this agency's contract are to provide the following services:
    (a) Consultation services to mental health providers working with the Asian-Pacific Community
    (b) Develop a preventative program for Asian-Pacific American youths
    (c) Assist Asian-Pacific Communities find relevant mental health services
(2) Hope Rehabilitation Services. This contract is for the purpose of consulting with developmentally disabled children and their families on such areas as future expectations, realistic expectations, how to work with a developmentally disabled son or daughter, etc.
(3) Gardner Community Health Center, Inc. This agency provides preventative mental health services through the delivery of bilingual and

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[21]Santa Clara Health Department. 1980-1981 Santa Clara County Mental Health Services, County Plan Phase I. (San Jose, CA: Santa Clara Mental Health Bureau, 1980).

> bicultural outreach and education services. Additionally, the center staff consult with different community care-giving agencies on how to provide more relevant Spanish-speaking mental health services.[22]

Alameda County Mental Health System. Alameda County provides a wide range of mental health services to its residents through a variety of county-operated and community-based organizations. These services include Inpatient Services, Outpatient Services, Partial Day Services and twenty-four Emergency Programs, Consultation and Community Education Services, Diagnostic and Rehabilitation Programs, Training, and a network of programs related to the needs of the mentally ill pre-acute and post-acute care.

In recent years, Alameda County Mental Health Services has developed new and expanded programs that reduce dependence on state mental hospitals and allows for treatment and rehabilitation in the local communities. Among these new and/or expanded programs are:

(1) La Cheim Program. A daytime treatment and residential program for adolescents
(2) Villa Fairmont. A 99-bed skilled nursing facility for persons between 16 and 55 years of age needing sub-acute rehabilitative care
(3) Garfield Home. A 99-bed skilled nursing facility for the geriatric population
(4) South Region Children's Day Treatment. A day-time treatment program for youngsters between 9 and 14 years
(5) Criminal Justice/Mental Health Inpatient. The expansion of the program to accommodate the

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[22] Ibid.

increased needs and provide acute mental health care for female clients

(6) Substitute Payee Program. A personal financial management service for chronic mentally ill adults.[23]

Recent reorganization within the county's Mental Health Services focused on the creation of the offices of children services, adult services, advocacy services, program development and evaluation, quality assurance and training, and fiscal management. The county has approximately twenty-five community based non-county operated mental health agencies that provide mental health related services for its local citizens.

Solano County Mental Health System. Solano County is the major provider of mental health services with less than 10 percent of the county funded services being contracted out to other mental health service providers.[24] Private mental health providers in the county are in short supply relative to the abundance of mental health professionals in the eight other Bay Area counties.

The county's mental health services are regionally subdivided into two areas--North County Region and South County Region. North County Mental Health Services serves

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[23]Alameda County Health Care Agency. 1981 Annual Report. (Oakland, CA: 1981).

[24]Solano County Mental Health Services. Annual Plan for the Mental Health Services of Solano County 1981-1982 Phase I. (Fairfield, CA: Solano County Health Services, October 31, 1981).

Fairfield, Vacaville, Dixon, and Rio Vista through their satellite outpatients centers. In addition to the satellite centers, North County provides Adult Day Treatment services, Adult 24-hour Crisis House, Continuing Care Program, and Children Programs. South County Region provides Vallejo and Benicia with mental health services, such as outpatient services, children services, adolescent programs, and continuing care programs.[25]

Currently the county's mental health services does not provide an acute inpatient facility, however, their Crisis Unit and both county region outpatient services screen clients for referral to Napa State Hospital or an out-of-county private acute facility when appropriate. The dependence on Napa State Hospital for acute mental health services will soon be reduced once the plans for a new psychiatric unit at Vallejo's General Hospital becomes a reality.

The brief overview of each of the county's mental health programs presented above represents a general compliance for traditional mental health services in accordance with both federal and state guidelines. While their compliance is commendable, each of the counties falls short of being fully aware of the existence of Pacific Islanders in their respective communities. In general, mental health agency interaction with Pacific Islanders

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[25]Ibid.

was frequently limited or non-existent. The net result has been the lack of effective mental health representation and advocacy for a greater understanding of the psycho-social needs of Guamanian Americans and other Pacific Islanders in California.

CHAPTER VI

RESULTS

The data reported have been divided into four sections: (1) General demographic characteristics of the sample; (2) Mental health findings; (3) Utilization of formal health services and informal resources; and (4) Barriers to utilization of mental health services.

Demographic Characteristics

This section presents a general demographic profile of Guamanian Americans residing in three Northern California counties--Santa Clara, Alameda, and Solano. Table 1 shows the geographic distribution of the respondents at the time the interviews were conducted.

TABLE 1

RESPONDENTS' GEOGRAPHIC DISTRIBUTIONS

Geographic Origin	Number	Percent
Santa Clara County	272	49.7
Alameda County	164	29.9
Solano County	112	20.4
Total	548	100.0

The statistics for this research were drawn from interviews with 548 Guamanian Americans who are eighteen years or older. It should be noted that the sample size represents repondents and not households.

The sample size of 548 represents 3.1 percent and 11.6 percent of the total number of Guamanian Americans living in California (17,673) and the three counties (4,719) respectively. The sample's sex ratio was equally distributed (M/F = 274/247). Regarding age distribution, it appears that the present sample consists of a relatively large number of young adults under the age of thirty-nine. The sample's mean age is 33.8 and their median age is thirty years with ages ranging from eighteen to seventy-five years (see table 2).

The marital status profile shows that 59.3 percent of the respondents are married, 33.6 percent are single (never married), and 7.2 percent had been married, but are now widowed (2.2 percent), separated (1.5 percent), or divorced (3.5 percent). The relative absence of marital breakups (5.0 percent) indicated a community with a fairly traditional, stable marital life style. A contributing factor to this situation is Catholicism and their high percentage of intra-racial marriages (70.4 percent) suggesting a rather cohesive community, at least in relation to spousal preference (see Table 3).

TABLE 2

SEX AND AGE STATUS OF GUAMANIAN AMERICAN RESPONDENTS

Variables	Number	Percent
Sex		
Male	274	50.0
Female	274	50.0
Total	548	100.0
Age		
18-19	64	11.7
20-29	187	34.1
30-39	129	23.5
40-49	91	16.6
50-59	45	8.2
60-69	26	4.7
70+	5	0.9
Not Answered	1	0.2
Total	548	100.0

NOTE: Mean age, 33.8; median age, 30.0; standard deviation, 13.3.

TABLE 3

MARITAL STATUS AND ETHNICITY
OF RESPONDENTS' SPOUSE

Variables	Number	Percent
Marital Status		
Single	184	33.6
Married	325	59.3
Widowed	12	2.2
Separated	8	1.5
Divorced	19	3.5
Total	548	100.0
Ethnicity of Spouse		
Guamanian	254	70.4
Other	107	29.6
Total	361	100.0

The educational attainment of the sample ranged from three to twenty-one years, with 12.5 mean years of schooling. Almost 20 percent had less than a twelfth grade education, while at the other end of the continuum, 43.1 percent were post high school graduates or held higher academic degrees. The results tend to suggest that overall the respondents are not educationally deprived, but are educationally motivated and view education as a means for economic and social advancement.

Although education is highly regarded within the Guamanian American community, it should be noted that of the total number of people pursuing a college education, 71.5 percent never finished a four year degree program. Compared to the U.S. population as a whole, the Guamanian Americans can be considered to be over-represented in the lower education attainment categories and under-represented at the higher levels (see table 4).

TABLE 4

EDUCATIONAL LEVELS OF THE GUAMANIAN AMERICAN RESPONDENTS

Variables	Number	Percent
Education		
Elementary		
1-3	6	1.1
5-8	37	6.8
High School		
1-3	64	11.7
4	204	37.2
College		
1-3	168	30.7
4	38	6.9
5+	29	5.3
Don't Know	2	0.3
Total	548	100.0

NOTE: Mean years of schooling, 12.5.

The data on household income is based on income ranges. Therefore, the average household income of $22,000 is an estimated figure. The average range of household income of the sample varied from $20,000 to $25,000 per year. At first glance, this figure appears to be impressive, however, the data also shows that 65.7 percent of the household surveyed listed at least two or more people earning incomes. Traditionally, every income producing member in the household contributes a substantial amount of his/her earnings to the family (see table 5).

These results show the traditional Guamanian American household pattern, where the family's needs and demands often have priority over the needs of the individual members. The family unit maintains prominence within the psychological life of the individual, primarily because of its ability to provide emotional and material security. Upon closer consideration of these relevant factors, the results of the household income structure would indicate a lower economic status and/or buying power of the Guamanian American households.

This interpretation gains more credibility if one considers that the average number of people in a Guamanian household is six. Ishikawa (1979),[1] Munoz (1979),[2] and

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[1]Wesley H. Ishikawa, The Elder Guamanian (The Center on Aging, San Diego: The Campanile Press, 1978).

[2]Faye U. Munoz, "An Exploratory Study of Island Migration: Chamorro of Guam," (D.S.W. Dissertation, University of California, Los Angeles, 1979).

TABLE 5

TOTAL FAMILY INCOME AND NUMBER OF INCOME-EARNERS IN THE HOUSEHOLD

Variables	Number	Percent
Household Income ($)		
0-6,999	28	5.1
7,000-14,999	95	17.3
15,000-24,999	152	27.7
25,000-39,999	153	27.9
40,000+	95	17.3
Don't Know	13	2.4
Not Answered	12	2.2
Total	548	100.0
Number of Income-Earners in the Household		
One	188	34.3
Two	205	37.4
Three	61	11.1
Four	49	8.9
Five	11	2.0
Six	4	0.7
Seven	2	0.4
None	28	5.1
Total	548	100.0

NOTE: Estimated mean income, $22,000; Estimated mean income range, $20,000-$25,000.

del Valle (1979)[3] found in their research on Guamanian Americans that the average number of persons in the household was six.

The occupational profiles (see table 6) show that more than half (62.2 percent) were employed full-time, while sixty-four respondents (11.6 percent) were either employed part-time or were unemployed. The remaining respondents were housewives, students, or retired and, therefore, excluded from labor force considerations. The low incidence of unemployment (5.8 percent) and part-time employment (5.8 percent) does not necessarily mean that Guamanian Americans are not experiencing employment problems. It is suspected that if the respondents have employment problems, it may be due to underemployment rather than unemployment.

The respondents' occupational background reveals that 71.6 percent were engaged in blue collar work and are under-represented in professional and managerial occupations. In terms of the occupational categories adopted by the U.S. Census, 21.2 percent of the employed respondents were clerical workers, 11.1 percent were service workers, 10.1 percent were craftsmen, 14.9 percent were operatives, and 8.2 percent were laborers. Together,

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[3]Teresa del Valle, Social and Cultural Change in the Community of Umatac, Southern Guam (Micronesian Area Research Center, University of Guam, 1979).

TABLE 6

EMPLOYMENT STATUS AND OCCUPATIONAL CATEGORIES OF THE GUAMANIAN AMERICAN RESPONDENTS

Variables	Number	Percent
Employment Status		
Full-time	341	62.2
Part-time	32	5.8
Unemployed	32	5.8
Housewives	76	13.9
Students	49	8.9
Retired	18	3.3
Total	548	100.0
Occupational Categories		
Professional	67	17.8
Managerial	40	10.6
Clerical	80	21.2
Sales Workers	15	3.9
Craftsmen	38	10.1
Operatives	56	14.9
Transport Operatives	7	1.9
Laborers	31	8.2
Farmer	1	0.3
Service Workers	42	11.1
Total	377	100.0

these five occupational categories constitute 65.5 percent of all reported occupations.

A large proportion of the sample (89.4 percent) were born in Guam, while most of the remaining respondents were born in the Continental United States (see table 7). Among the respondents, 6.2 percent migrated to the United States before 1950, 20.3 percent came between 1951 and 1961, 23.7 percent came between 1962 and 1969, and 49.9 percent came since 1970. In other words, almost half of the respondents came to the United States and California during the past eleven years and 93.8 percent came since 1951.

In terms of their frequency of return trips to Guam, the results show that 223 respondents (40.7 percent) visited the Island at least once every one to two years (often), 145 (26.5 percent) every three to six years (sometimes), 109 (19.9 percent) every seven or more years (rarely), and 71 respondents (13 percent) reported never. Return visits to Guam are often prompted by sickness or death among family members as well as for renewing family and friendship ties.

In short, the results indicate that the respondents are recent settlers in the Bay Area. Furthermore, it can be said that maintaining family and friendship ties with the Island is important despite the geographic distance and financial requirements one must overcome while

TABLE 7

BIRTHPLACE, NUMBER OF YEARS LIVED IN UNITED STATES, AND RETURN VISITS TO GUAM

Variables	Number	Percent
Place of Birth		
Guam	490	89.4
USA	55	10.0
Other	3	0.6
Total	548	100.0
Years Lived in USA		
31-45 (before 1950)	32	6.2
26-30 (1955-1951)	44	8.5
20-25 (1961-1956)	61	11.8
16-19 (1965-1962)	46	8.9
12-15 (1969-1966)	77	14.8
8-11 (1973-1970)	61	11.8
4- 7 (1977-1974)	118	22.7
6 months-3 years (1981-1978)	80	15.4
Total	519	100.0
Return Visits to Guam		
Never	71	13.0
Rarely (7+ years)	109	19.9
Sometimes (3-6 years)	145	26.5
Often (1-2 years)	223	40.7
Total	548	100.0

traveling back to Guam. For example, an economy round trip airfare from San Francisco to Guam would cost $1,308 per person.

The ability to speak English is a demographic characteristic most often used to measure the degree of acculturation or westernization of immigrant groups in America. It is appropriate to consider this variable as an indication of the degree to which Americanization has taken place among the respondents. It should be noted that the Americanization process started almost eight decades ago when the United States took possession of Guam.

Unlike their Spanish predecessors, who offered the Spanish language as a vehicle for wider communication, the United States Naval government made English the Island's official language and prohibited the use of Chamorro as a language suitable for conducting official business. In their homes and in their own social groups, the local people usually speak Chamorro. Generally, whether fluent or otherwise, most Guamanian Americans speak English in a manner that is both readily communicated and understood (see table 8).

The results show that 85 percent of the respondents spoke both English and Chamorro in the household, 12.8 percent spoke English exclusively, and 2.2 percent spoke English and some other languages.

TABLE 8

HOUSEHOLD LANGUAGE OF THE GUAMANIAN AMERICAN RESPONDENTS

Variables	Number	Percent
Household Language		
Chamorro/English	466	85.0
English Only	70	12.8
English/Other	12	2.2
Total	548	100.0

If the demographic characteristics of language truely measures acculturation and westernization, then the household language profile of the respondents indicate a relatively successful Americanization (in terms of language) of Guamanian Americans. A more accurate and concrete interpretation of the results is that Guamanian Americans are simply bilingual. Although the Chamorro language has been subjected to external forces threatening its continued existence both here in the continental United States and in Guam, it will continue to exist, although in modified form, because it is a language of intimacy and culture of the present day Guamanian Americans.

Under the U.S. Naval government, the Chamorro were introduced to compulsory education, which emphasized

language and democratic ideals that are often in conflict with the authoritarian structure of the Chamorro family.

Learning the English language, in addition to the Chamorro language, have often been a source of problems and conflicts among the Guamanian Americans and between the Guamanian Americans and the dominant English speaking people in the United States. The English that the Guamanian Americans have learned, compared to the English speaking people, is often acquired through much more limited language experiential background.

In school and at work the Guamanian American is often teased or embarrassed for not speaking proficient English or for speaking with a "funny accent." Likewise, a reverse situation often occurs with Guamanian Americans who speak little or no Chamorro. Again the Guamanian American who does not speak the Chamorro language is often quietly belittled as trying to become more "Americano" which has a negative connotation. Needless to say, such double binds do little to enhance one's self-esteem. The potential loss of cultural/self identification and confusion is perhaps the most detrimental effect of attempting to live in or assimilate into a society such as that of the United States.

Guamanian Americans, like most Pacific Islanders, are known to be gregarious. However, it appears that

their gregarious behavior does not extend into participation in formal organizations but rather are directed more towards informal social and familial relationships (see table 9).

The results tend to confirm this preference since 63 percent of the respondents do not belong to any organization. Among those who did belong to one or more organization (n = 202), 18.6 percent were members of Guam clubs, 5.3 percent were members of religious clubs, 5.1 percent joined military retiree organizations, and 19.7 percent were members of other American social and civic organizations, such as the Moose Lodge, Rotary, Kiwanis, etc.

Inherent in rendering a profile of a group is the potential danger that it may create erroneous stereotyping. Therefore caution should be used since the results of the research may differ to some degree along a variety of dimensions and/or a particular feature of the demographic profile.

The typical Guamanian American respondent in this research is a young adult (early thirties), is probably married, born in Guam, and has lived in the United States for at least ten years. Educationally, he/she is reasonably educated. The respondents would almost certainly be a graduate from high school and probably has some education beyond high school.

TABLE 9

MEMBERSHIP AND TYPES OF ORGANIZATIONS THE GUAMANIAN AMERICAN RESPONDENTS PARTICIPATED IN

Variables	Number	Percent
Membership		
Yes	202	36.9
No	346	63.1
Total	548	100.0
Types of Clubs		
Guam Clubs:		
Yes	102	18.6
No	446	81.4
Total	548	100.0
Religious Clubs:		
Yes	29	5.3
No	519	94.7
Total	548	100.0
Retired Military Clubs:		
Yes	28	5.1
No	520	94.9
Total	548	100.0
Other American Clubs:		
Yes	108	19.7
No	440	80.3
Total	548	100.0

In terms of reported family income, the respondents are doing fairly well and are quite capable of meeting their basic needs for economic survival. They probably hold full-time jobs somewhere between the middle and the bottom half of the occupation ladder.

English proficiency does not appear to be a major problem for the Guamanian American, who can at least understand spoken English and is often quite fluent in English. Within their ethnic/social and familial structures, the Chamorro language is spoken quite often.

There is a likelihood that the respondents are Catholic. Other than being members of the Catholic Church, the respondents appear to limit their participation to seasonal/traditional religious observances. Aside from their membership with the Church, he/she is not much of a joiner in other voluntary associations. If he/she belongs to any organization, it is usually limited to one or two social and/or civic clubs. This does not necessarily mean that Guamanian Americans are apathetic about community activities but rather indicates a preference to associate with members of the extended family and friends on an informal basis.

It does, however, indicate that participation in organizations outside the extended family or ethnic group is not highly regarded and that participation in such organizations lack intrinsic value or direct benefits

to the extended family and/or the Guamanian American community. Another possible consideration for not being a joiner of community based organizations and activities is the general feelings of impotence in being able to contribute or advocate changes for the benefit of the family and/or the Guamanian American community.

Mental Health Findings

This section will present the findings based on the premise that psychiatric symptoms and related dysfunction are not randomly distributed but rather cluster among certain social and demographic groups and the research question regarding the mental health service needs of Guamanian Americans. These findings are grouped into three areas: (1) respondent(s) psychiatric symptom/dysfunction scale scores by their social and demographic characteristics; (2) estimated rates of mental health service needs (low, moderate, and high); and (3) a summary of the mental health findings.

As indicated in chapter 4, a statistical normative model was employed in determining the estimates of mental health service needs. This model assumes that the average is normal. In other words, those who scored higher than one standard deviation above the mean on each of the psychiatric symptom/dysfunction scales are

considered to be high risk and would probably be in need of and could benefit from mental health services.

For example, in Warheit's (1980) assessment of mental health services in California, he found that people who scored high on all the psychiatric symptom/dysfunction scales had very high levels of psychosocial impairment in almost every area of their personal and social lives.[4] This group was commonly unemployed; had fewer coping resources; they are more often on psychotropic drugs; they frequently abuse alcohol; and they have high levels of suicidal ideation and behavior. They also have extremely negative perceptions of their physical and mental well-being and they are frequent users of a wide range of human services.[5]

Psychiatric Symptom/Dysfunction Scale Scores. The following psychiatric symptom/dysfunction scales were utilized to establish the estimated rates for mental health services: (1) Anxiety, (2) Depression, (3) Psychosocial Dysfunction, (4) General Psychopathology, and Cognitive Impairment.

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[4]George J. Warheit, "An Assessment of the need for Mental Health and Alcohol Related Services in the State of California." (Funded by the Division of Planning Development, Research and Evaluation, Department of Mental Health, State of California, Sacramento, CA: June 30, 1980).

[5]Ibid., pp. III-9.

These subscales were selected by Warheit because anxiety and depression are symptoms and conditions most commonly reported in mental health field studies. The psychosocial dysfunction was chosen because this scale measures the behavioral consequences of psychiatric symptomatology rather than symptom alone. The general psychopathology and cognitive impairments were selected because they ascertain symptoms and syndromes not indicated in the content of the other scales.[6]

The anxiety scale scores ranged from 0-44 (see table 10). The respondents' mean score and standard deviation score was 6.05 and 6.06 respectively. Of the total respondents, 15.9 percent scored in the high-risk range.

Disproportionately, more females scored in the high-risk range than males. Other groups with proportionately more respondents scoring in the high-risk range includes those aged 60+, respondents in the lowest household income ($0-$6,999), those with less than a high school education (1-4), and the widowed. Those groups with proportionate fewer respondents scoring in the high-risk range were those aged 40-49, the separated/divorced,

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[6]George J. Warheit, et al., "An Epidemiologic Assessment of Mental Health Problems in the Southeastern United States." (Funded by the National Institute of Mental Health Grants MH 15900 and MH 24740, 1969).

TABLE 10

ANXIETY SCALE SCORES BY SEX, AGE, MARITAL STATUS, EDUCATION, AND HOUSEHOLD INCOME

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Total	548	100.0	6.05	6.06		15.9
Sex						
Males	274	50.0	5.39	5.82	t = -2.55*	12.0
Females	274	50.0	6.71	6.23		19.8
Age						
18-19	64	11.7	7.34	6.63	ANOVA	23.4
20-29	187	34.2	6.41	5.89	F = 2.52*	18.2
30-39	129	23.6	6.02	6.01	df = 6,540	14.0
40-49	91	16.6	4.09	5.47	R = 0.165	7.7
50-59	45	8.2	5.91	5.94		11.1
60-69	26	4.8	7.46	7.06		26.9
70+	5	0.9	7.60	7.11		20.0
Marital Status						
Single	184	33.6	6.26	5.79	ANOVA	16.8
Married	325	59.3	5.94	6.18	F = 1.42	15.1
Widowed	12	2.2	9.33	8.54	df = 6,539	33.3
Separated	8	1.5	4.00	4.00	R = 0.102	12.5
Divorced	19	3.5	4.74	5.04		10.5
Education						
Elem. (1-4)	6	1.1	13.33	7.66	ANOVA	50.0
Elem. (5-8)	37	6.8	9.92	6.28	F = 3.47***	21.6
H. S. (1-3)	64	11.7	7.34	8.02	df = 6,539	26.6
H. S. (4)	204	37.4	6.31	5.88	R = 0.193	13.7
Col. (1-3)	168	30.8	4.92	5.46		12.5
Col. (4)	38	7.0	4.84	4.33		10.5
Col. (5)	29	5.3	6.41	5.30		17.2

TABLE 10--continued

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Household Income						
$0-$6,999	28	5.4	8.71	7.08	ANOVA	28.6
$7,000-$14,999	95	18.2	6.51	5.52	F = 3.27*	20.0
$15,000-$24,999	152	29.1	6.47	6.72	df = 4,518	15.8
$25,000-$39,999	153	29.3	5.80	5.85	R = 0.157	15.0
$40,000+	95	18.2	4.51	5.50		9.5

*p < .05; **p < .01; ***p < .005; ****p < .001.

respondents with a college education and those in the highest household income bracket.

Barring any organic or physical causes, a person scoring high on the anxiety scale could experience a variety of symptoms and behaviors that could affect even their most routine activities. For example, loss of appetite or energy, psychosomatic ailments, free floating fears, apprehension, and uncertainty in the absence of known causes.

The depression scale scores ranged from 0-64 (see table 11). The respondents' mean score and standard deviation score was 14.2 and 8.27 respectively. Again, females as a group had a higher depression mean score (15.51) as compared to males (12.95). They also had a greater number of respondents (n = 54) in the high-risk range than did their male counterpart (n = 38).

TABLE 11

DEPRESSION SCALE SCORES BY SEX, AGE, MARITAL STATUS, EDUCATION, AND HOUSEHOLD INCOME

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Total	548	100.0	14.23	8.27		16.8
Sex						
Males	274	50.0	12.95	7.91	t = -3.66****	13.9
Females	274	50.0	15.51	8.44		19.7
Age						
18-19	64	11.7	17.22	7.94	ANOVA	29.7
20-29	187	34.2	15.74	8.40	F = 6.76****	19.8
30-39	129	23.6	14.36	8.89	df = 6,540	17.8
40-49	91	16.6	10.64	6.38	R = 0.264	5.5
50-59	45	8.2	11.53	7.37		6.7
60-69	26	4.8	13.31	6.86		15.4
70+	5	0.9	10.00	9.51		20.0
Marital Status						
Single	184	33.6	15.75	7.63	ANOVA	22.3
Married	325	59.3	13.28	8.46	F = 2.79*	13.2
Widowed	12	2.2	15.08	10.67	df = 4,543	41.7
Separated	8	1.5	16.13	10.33	R = 0.142	25.0
Divorced	19	3.5	14.32	6.63		5.3
Education						
Elem. (1-4)	6	1.1	17.17	8.01	ANOVA	33.3
Elem. (5-8)	37	6.8	12.43	7.91	F = 3.17***	13.5
H. S. (1-3)	64	11.7	16.73	11.26	df = 6,539	31.3
H. S. (4)	204	37.4	15.09	7.78	R = 0.185	16.2
Col. (1-3)	168	30.8	12.82	7.20		14.9
Col. (4)	38	7.0	12.03	7.39		5.3
Col. (5+)	29	5.3	15.24	9.49		17.2

TABLE 11--continued

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Household Income						
$0-$6,999	28	5.4	19.50	8.44	ANOVA	39.3
$7,000-$14,999	95	18.2	16.41	9.00	F = 7.97****	21.1
$15,000-$24,999	152	29.1	14.05	8.02	df = 4,518	14.5
$25,000-$39,999	153	29.3	13.86	7.60	R = 0.241	16.3
$40,000+	95	18.2	11.28	7.83		8.4

*p< .05; **p< .01; ***p < .005; ****p < .001.

Proportionately, as a group, the widowed person had both a significantly higher mean depression score and a higher number of respondents in the high-risk range than did the rest of the other three marital status. Respondents in both the lowest educational attainment level (1-4) and the lowest household income bracket ($0-6,999) scored proportionately more on the high-risk range and had a higher mean depression scale score as compared to the other educational levels and household income brackets. There was an inverse relationship between age and depression, where late adolescents (18-19) were shown to be depressed.

The psychosocial dysfunction responses ranged from 0-44 (see table 12). The mean score was 3.18 and the standard deviation was 5.38. Of the total sample, 57 respondents (10.4 percent) scored one or more standard deviation above the mean and therefore are in the high-risk range.

TABLE 12

PSYCHOSOCIAL DYSFUNCTION SCALE SCORES BY SEX, AGE, MARITAL STATUS, EDUCATION, AND HOUSEHOLD INCOME

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Total	548	100.0	3.18	5.38		10.4
Sex						
Males	274	50.0	2.63	4.96		8.0
Females	274	50.0	3.72	5.73	t = -2.39*	12.8
Age						
18-19	64	11.7	4.35	5.08	ANOVA	12.5
20-29	187	34.2	3.60	6.19	F = 3.40***	13.9
30-39	129	23.6	3.87	6.09	df = 6,540	14.0
40-49	91	16.6	1.32	2.19	R = 0.191	1.1
50-59	45	8.2	2.47	4.56		4.4
60-69	26	4.8	1.62	2.62		3.8
70+	5	0.9	4.40	7.70		20.0
Marital Status						
Single	184	33.6	3.40	5.32	ANOVA	11.4
Married	325	59.3	2.99	5.43	F = 0.43	9.5
Widowed	12	2.2	3.67	5.40	df = 4,543	8.3
Separated	8	1.5	5.00	7.19	R = 0.056	25.0
Divorced	19	3.5	3.16	4.57		10.5
Education						
Elem. (1-4)	6	1.1	5.83	6.18	ANOVA	16.7
Elem. (5-8)	37	6.8	2.24	4.15	F = 2.46*	5.4
H. S. (1-3)	64	11.7	4.83	8.70	df = 6,539	15.6
H. S. (4)	204	37.4	3.34	5.06	R = 0.163	9.8
Col. (1-3)	168	30.8	2.67	4.59		11.9
Col. (4)	38	7.0	1.55	2.26		0.0
Col. (5+)	29	5.3	4.03	5.59		13.8

TABLE 12--continued

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Household Income						
$0-$6,999	28	5.4	5.04	6.64	ANOVA	17.9
$7,000-$14,999	95	18.2	4.40	6.43	F = 2.59*	16.8
$15,000-$24,999	152	29.1	2.99	5.20	df = 4,518	8.6
$25,000-$39,999	153	29.3	2.67	4.40	R = 0.140	8.5
$40,000+	95	18.2	2.71	5.77		9.5

*p< .05; **p < .01; ***p< .005; ****p < .001.

Females had a significantly higher mean scale score (3.72) than the males (2.63). Also, more females scored one or more standard deviation above the mean than did their male counterpart. Other groups with proportionately more respondents scoring in the high-risk range were, the aged (70+), the separated, respondents with the lowest education attainment level, and those in the lowest household income bracket. The groups with proportionately fewer respondents in the high-risk range were: those aged 40-49, the widowed, respondents with at least four years of college, and those with a household income of $25,000-39,999.

Responses on the general psychopathology ranged from 0-32 (see table 13). The sample's mean and standard deviation was 7.92 and 4.49 respectively. On this subscale 19.7 percent of the respondents (n = 108) scored in the high-risk range.

TABLE 13

GENERAL PSYCHOPATHOLOGY SCALE SCORES BY SEX, AGE, MARITAL STATUS, EDUCATION, AND HOUSEHOLD INCOME

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Total	548	100.0	7.92	4.49		19.7
Sex						
Males	274	50.0	7.36	4.35	t = -2.92	18.2
Females	274	50.0	8.48	4.56		21.2
Age						
18-19	64	11.7	9.53	4.64	ANOVA	28.1
20-29	187	34.2	8.66	4.61	F = 7.03****	21.9
30-39	129	23.6	8.21	4.57	df = 6,538	24.0
40-49	91	16.6	6.48	3.66	R = 0.270	11.0
50-59	45	8.2	6.13	3.59		8.9
60-69	26	4.8	5.84	3.95		11.5
70+	5	0.9	4.00	3.39		0.0
Marital Status						
Single	184	33.6	8.59	4.39	ANOVA	21.7
Married	325	59.3	7.58	4.54	F = 2.40*	18.8
Widowed	12	2.2	5.75	4.69	df = 4,541	16.7
Separated	8	1.5	9.25	4.77	R = 0.132	25.0
Divorced	19	3.5	8.05	3.37		15.8
Education						
Elem. (1-4)	6	1.1	6.67	3.44	ANOVA	16.7
Elem. (5-8)	37	6.8	6.61	5.05	F = 3.34***	21.6
H. S. (1-3)	64	11.7	9.48	6.55	df = 6,537	32.8
H. S. (4)	204	37.4	8.46	4.23	R = 0.190	21.1
Col. (1-3)	168	30.8	7.38	3.89		16.1
Col. (4)	38	7.0	7.42	3.41		13.2
Col. (5+)	29	5.3	6.66	3.35		10.3

TABLE 13--continued

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Household Income						
$0-$6,999	28	5.4	9.29	4.50	ANOVA	28.6
$7,000-$14,000	95	18.2	8.75	4.84	F = 3.24*	23.2
$15,000-$24,999	152	29.1	7.54	4.41	df = 4,515	16.4
$25,000-$39,999	153	29.3	8.11	4.21	R = 0.157	23.5
$40,000+	95	18.2	6.86	4.14		12.6

*p < .05; **p < .01; ***p < .005; ****p < .001.

The groups with more respondents scoring in the high-risk range were females, those aged 18-39, the separated, respondents who had at least three years of high school but never graduated, and those with the lowest household income.

The cognitive impairment scale scores ranged from 0-16 (see table 14). The respondents' mean score and standard deviation score was 3.10 and 2.59 respectively. Of the total sample 16.4 percent scored in the high-risk range and of that figure, women had a disproportionately larger number of respondents scoring one or more standard deviation above the mean.

Other groups with proportionately more respondents scoring in the high-risk range include those aged 70+, the separated, respondents with less than a high school education, and those with a household income range of $0-6,999.

TABLE 14

COGNITIVE IMPAIRMENT SCALE SCORES BY SEX, AGE, MARITAL STATUS, EDUCATION, AND HOUSEHOLD INCOME

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Total	548	100.0	3.10	2.59		16.4
Sex						
Males	274	50.0	2.72	2.59	t = -3.51****	13.5
Females	274	50.0	3.49	2.64		19.3
Age						
18-19	64	11.7	3.33	2.32	ANOVA	18.8
20-29	187	34.2	3.40	2.53	F = 1.63	17.6
30-39	129	23.6	3.11	2.84	df = 6,540	19.4
40-49	91	16.6	2.41	2.14	R = 0.133	8.8
50-59	45	8.2	2.91	2.38		13.3
60-69	26	4.8	3.12	3.68		19.2
70+	5	0.9	3.40	3.44		20.0
Marital Status						
Single	184	33.6	3.32	2.34	ANOVA	16.8
Married	325	59.3	2.95	2.64	F = 1.526	16.3
Widowed	12	2.2	3.67	4.42	df = 4,543	16.7
Separated	8	1.5	4.50	2.93	R = 0.105	25.0
Divorced	19	3.5	2.58	2.34		10.5
Education						
Elem. (1-4)	6	1.1	4.33	2.66	ANOVA	16.7
Elem. (5-8)	37	6.8	2.78	3.31	F = 1.323	18.9
H. S. (1-3)	64	11.7	3.59	3.20	df = 6,539	28.1
H. S. (4)	204	37.4	3.20	2.49	R = 0.120	15.2
Col. (1-3)	168	30.8	2.77	2.34		14.3
Col. (4)	38	7.0	3.11	1.52		7.9
Col. (5)	29	5.3	3.52	3.16		20.7

TABLE 14--continued

Variables	N	%	$\bar{X}$	SD	Sig.	%High
Household Income						
$0-$6,999	28	5.4	3.89	2.44	ANOVA	25.0
$7,000-$14,999	95	18.2	3.26	2.41	F = 1.002	15.8
$15,000-$24,999	152	29.1	3.01	2.94	df = 4,518	16.4
$25,000-$39,999	153	29.3	3.20	2.50	R = 0.088	20.3
$40,000+	95	18.2	2.86	2.51		11.6

*p < .05; **p < .01; ***p < .005; ****p < .001.

Estimated Rates of Need for Mental Health Services. The estimated mental health service needs for Guamanian Americans in the three counties were based on the five symptom/dysfunction scale scores described earlier. Briefly, the procedures whereby the rates of mental health service needs was established for the various social and demographic groups, such as age, sex, and so forth are as follows: First, a statistical distribution of scores were prepared for the entire sample. Then, mean scores were determined and standard deviations established. Once standard deviations were computed for the entire sample, the population was divided into several categories.

Respondents whose scores on all five symptom/dysfunction scales were below one standard deviation above the mean were defined as being in the normal range. Those whose scores ranged from one or more standard deviation

above the mean on one or two of the scales were identified at low risk. Next, those with scores one or more standard deviation above the mean for three or four of the scales were identified as being in the moderate risk category. Those scoring one or more standard deviation above the mean on all five scales were defined as being at high risk for mental health problems.

The normal category was considered to be in no need or improbable need of mental health programs/services; those in the low need category were judged to be in need or indirect mental health services, such as, consultation and education programs. Those in the moderate need group were classified as being in probable need of outpatient services and those in the high need group were considered to be highly symptomatic and dysfunctional and therefore likely to benefit from direct mental health services.

The percentage of the total sample falling into each of these mental health service need categories are as follows: Normal Need--61.9 percent; Low Need--26.1 percent; Moderate Need--9.7 percent; and High Need--2.4 percent. Table 15 presents four levels of mental health service needs by the respondents sociodemographic characteristics.

Of the four mental health service needs (normal, low, moderate, and high), the normal category had more male respondents than female respondents. Proportionately,

TABLE 15

ESTIMATED LEVELS OF MENTAL HEALTH SERVICE NEEDS BASED ON PSYCHIATRIC SYMPTOM/DYSFUNCTION SCALE SCORES

Variables	Scales High						
	N	%	Normal Need	Low Need	Moderate Need	High Need	X^2
Total	548	100.0	61.9	26.1	9.7	2.4	
Sex							
Males	274	50.0	66.4	23.7	8.4	1.5	
Females	274	50.0	57.3	28.5	10.9	3.3	NS
Age							
18-19	64	11.7	51.6	28.1	18.8	1.6	
20-29	187	34.2	57.8	28.3	10.7	3.2	
30-39	129	23.6	58.9	27.1	10.1	3.9	
40-49	91	16.6	75.8	20.9	3.3	0.0	NS
50-59	45	8.2	73.3	24.4	0.0	2.2	
60-69	26	4.8	65.4	19.2	15.4	0.0	
70+	5	0.9	60.0	20.0	20.0	0.0	
Marital Status							
Single	184	33.6	58.7	26.1	13.6	1.6	
Married	325	59.3	64.0	26.2	7.1	2.8	
Widowed	12	2.3	50.0	25.0	25.0	0.0	NS
Separated	8	1.5	62.5	12.5	12.5	12.5	
Divorced	19	3.5	63.2	31.6	5.3	0.0	
Education							
Elem. (1-4)	6	1.1	50.0	16.7	33.3	0.0	
Elem. (5-8)	37	6.8	64.9	24.3	8.1	2.7	
H. S. (1-3)	64	11.7	51.6	21.9	18.8	7.8	
H. S. (4)	204	37.4	61.3	28.4	7.8	2.5	*
Col. (1-3)	168	30.8	65.5	23.2	10.1	1.2	
Col. (4)	38	7.0	73.7	26.3	0.0	0.0	
Col. (5)	29	5.3	51.7	37.9	10.3	0.0	

TABLE 15--continued

Variables	N	%	Scales High: Normal Need	Low Need	Moderate Need	High Need	X^2	
Household Income								
$0-$6,999	28	5.4	46.4	25.0	25.0	3.6		
$7,000-$14,999	95	18.2	54.7	29.5	12.6	3.2		
$15,000-$24,999	152	29.1	63.8	28.3	5.3	2.6	*	
$25,000-$39,999	153	29.3	58.2	28.8	10.5	2.6		
$40,000+	95	18.2	74.7	16.8	7.4	1.1		

*p< .05; **p< .01; ***p< .005; ****p< .001

the normal group can be broadly described as older adults (40-59), married, well educated, and well off financially. In contrast, the low need group had proportionately more respondents who were young adults (18-29), divorced, and also well educated but with lower household incomes between $7,000-14,999.

The data suggest that the low need group represent those in the Guamanian American population who would most likely benefit from consultation, education, and programs of prevention and early intervention. However, the indications are that they would not be likely to visit mental health facilities for help, except occasionally and/or if some significant event were to occur in their lives.

Proportionately, the moderate need group had more senior citizens (70+), widowed, respondents with less than a fifth grade education, and those with a household income less than $7,000. Generally, the moderate group had significantly lower levels of functionality, physical, and support networks than the normal and low need groups, on the one hand, and higher levels of functionality and so forth than the high need group on the other.

The results suggest that for the most part respondents in this group, although significantly symptomatic, had sufficient levels of functionality and support to warrant some degree of direct mental health, such as oupatient services. It should be noted that the moderate need group, like their counterparts in the normal and low need groups, would also not be inclined to seek mental health services voluntarily.

The high need group had proportionately more respondents who were young adults (30-39), separated, in the lowest educational level (less than a fifth grade education), and household income brackets ($0-6,999). The respondents in the high need group had a lower perception of physical and mental health well-being than did the other three need groups. They are frequent users of a wide range of human services and had a compatible level of support networks with the normal, low, and moderate need groups. The existence of support networks are often an extension and

function of the respondents' immediate family and close friends. It is a typical behavior pattern among Guamanian Americans to accept or tolerate someone who is either physically or mentally ill because of their familial and/or friendship relationships and obligations.

If one combines the results of both the moderate need and high need groups it would constitute 12.1 percent of the total sample in need of some form of direct mental health services. The result indicates that at any given time approximately 6,655 Guamanian Americans, over the age of eighteen in California, have enough psychological distress to have a clear reduction in their mental health well-being and as such need some form of helpful intervention which might vary from crisis counseling to hospitalization.

Summary of Mental Health Findings

Social indicators, such as sex, age, and marital status, are types of statistics used to measure and describe social conditions. Their primary function in this research is to provide an assessment or baseline of the mental health service needs of the Guamanian American people. The assessment of the mental health service needs is based on the research premise that psychiatric symptom/dysfunctions are not randomly distributed but rather cluster among certain social and demographic groups.

To this end the results of the psychiatric symptom/dysfunction scale scores and estimated rates of needers for mental health services clearly support the premise.

The data analysis, which included a T-test, a One-Way Analysis of Variance, and a Multiple Regression, disclosed that the especially high-risk groups were generally females, middle aged respondents (30-39), the separated/widowed, those with less than a high school education, and individuals with a total household income under $7,000. In contrast, respondents who were considered normal or low risk for mental health problems can be described in broad terms as being males, married, older adults (40-59), well-educated, and financially well-off.

The respondents' educational background and socioeconomic status were the most significant determinants of mental health services needs. The subpopulation that had a significant level of association ($p < .05$) with both the individual psychiatric symptom/dysfunction scale scores and the extrapolated estimation of service needs were respondents with a household income less than $7,000 and those with less than a high school education. Barring any overt discrimination against people of color, it is generally accepted that the amount of schooling partly determines the kinds of job obtained, the amount of money earned, and one's socioeconomic well-being.

In reference to the respondents' relative newness as immigrants to California and their overall socio-economic status, the results appear to confirm the notion that psycho-social problems experienced by Guamanian Americans are closely linked to problems of economic self-sufficiency and/or economic survival in America. To some degree, the results support the controversial social causation hypothesis that material and cultural improverishment produces both mental and physical illness and vice versa, to some degree both mental and physical illness contribute to material and cultural improverishment.

Utilization of Formal Health Services and Informal Resources

This section will examine respondents' utilization of both formal and informal services and resources. The utilization of formal health services are divided into two parts: (1) Physical health services, consisting of responses to items in the interview schedule concerning visits to medical doctors, dentists, chiropractors, public nurses, emergency rooms at a hospital, and health department clinics during the last year, and (2) Mental health services, which includes visits to psychiatrists, psychologists, social workers, family counselors, community mental health centers, other mental health facilities, alcoholism treatment clinics, drug abuse clinics, and vocational rehabilitation centers.

Utilization of informal resources consists of visits to religious persons, spiritualists, natural healers, close relatives, and friends living nearby with whom the respondents could seek help from and share their inner most thoughts and problems with these helpers. These findings will be helpful in gaining insight into the respondents' natural helping networks and their human service utilization patterns.

Tables 16 and 17 present a frequency distribution of the respondents' utilization of a wide range of physical and mental health care services. The data reveals that respondents are aware of the existence of physical health care services and overwhelmingly utilize these services.

Of the 548 respondents, 405 (74.2 percent) reported visiting a medical doctor during the past year, 333 respondents (60.8 percent) saw a dentist, 168 (30.7 percent) utilized an emergency room at a hospital, 64 (11.7 percent) visited a public health clinic, 45 (8.2 percent) saw a public health nurse, and 23 (4.2 percent) visited a chiropractor.

Only thirty-nine (7.1 percent) of the total sample reported using some form of mental health care or assistance during the preceeding year; 509 respondents (92.9 percent) had not utilized any form of mental health services. The percentage (7.1 percent) reported as receiving mental health care may be inflated because it

TABLE 16

UTILIZATION OF FORMAL PHYSICAL HEALTH CARE SERVICES DURING THE PAST YEAR

Variables	Number	Percent
Visits to a medical doctor in past year		
Yes	405	74.2
No	141	25.8
Visits to a dentist in past year		
Yes	333	60.8
No	215	39.2
Visits to a chiropractor in past year		
Yes	23	4.2
No	525	95.8
Visits to a public health nurse in past year		
Yes	45	8.2
No	503	91.8
Visits to an emergency room at a hospital in past year		
Yes	168	30.7
No	380	69.3
Visits to a health department clinic in past year		
Yes	64	11.7
No	484	88.3

TABLE 17

UTILIZATION OF FORMAL MENTAL HEALTH CARE SERVICES DURING THE PAST YEAR

Variables	Number	Percent
Visits to a psychiatrist in past year		
Yes	11	2.0
No	537	98.0
Visits to a psychologist in past year		
Yes	9	1.6
No	539	98.4
Visits to a vocational rehabilitation center		
Yes	9	1.6
No	539	98.4
Visits to a community mental health facility in past year		
Yes	9	1.6
No	539	98.4
Visits to some other mental health facility in past year		
Yes	9	1.6
No	539	98.4
Visits to an alcoholism treatment clinic in past year		
Yes	2	0.4
No	546	99.6

TABLE 17--continued

Variables	Number	Percent
Visits to a drug abuse treatment clinic in past year		
Yes	3	0.5
No	545	99.5
Visits to a family counselor in past year		
Yes	27	4.9
No	521	95.1
Visits to a social worker in past year		
Yes	39	7.1
No	509	92.9

includes those who gave affirmative answers to the question concerning visits to a social worker.

Although social workers do provide counseling services, it is suspected that in many instances their activities were directed primarily toward securing welfare or other benefits for their clients. Delineating with precision the type of services being provided by social workers is a difficult task because social workers are often located in multi-service health care centers that provide both mental health care and social services to the community.

Of the total sample, only eleven (2 percent) reported seeing a psychiatrist during the past year, nine (1.6 percent) visited a psychologist, a vocational rehabilitation center, a community mental health facility, and some other mental health facility, two respondents (0.4 percent) visited an alcoholism treatment clinic, three (0.5 percent) visited a drug abuse treatment clinic, twenty-seven (4.9 percent) saw a family counselor, and thirty-nine (7.1 percent) utilized the services of a social worker during the past year.

The highest utilization of formal health services was among the young (20-29), females, well educated respondents' with a household income ranging from $25,000 to $40,000. In contrast, under-utilizers of formal health services were the elderly (60+), those in the lowest education and household income level, the widowed, separated, or divorced person.

Table 18 presents the results of the respondents utilization of informal resources. The data reveals that only thirty-eight respondents (6.9 percent) visited a religious person during the past year, ten (1.8 percent) saw a spiritualist/psychic, and eleven (2 percent) utilized a natural healer.

Of the total sample, 516 respondents or 94.2 percent had close relatives living nearby with 451 or 87.4 percent stating that they could seek help from these relatives.

TABLE 18

UTILIZATION OF INFORMAL RESOURCES

Variables	Number	Percent
Visits to a religious person in past year		
Yes	38	6.9
No	510	93.1
Visits to a spiritualist/psychic in past year		
Yes	10	1.8
No	538	98.2
Visits to a natural healer in past year		
Yes	11	2.0
No	537	98.0
Close relatives nearby		
Yes	516	94.2
No	32	5.8
Could ask nearby relatives for help		
Yes	451	87.4
No	64	12.4
DK	1	0.2
Number of close relatives the respondents asked help or was given help from relatives in past year		
None	241	47.2
One	65	12.7
Two	57	11.2
Three	37	7.2
Four	24	4.7
Five	30	5.9
Six	6	1.2
Seven	7	1.4
Eight	3	0.6

TABLE 18--continued

Variables	Number	Percent
Nine	1	0.2
Ten	20	3.9
Eleven	1	0.2
Twelve	2	0.4
Fifteen	5	1.0
Sixteen	1	0.2
Eighteen	1	0.2
Twenty	5	1.0
Twenty-five	1	0.2
Thirty	4	0.8
How often see or talk with relatives who live nearby?		
Almost daily	195	37.6
Several times a week	177	34.2
Several times a month	101	19.5
Several times a year	25	4.8
Seldom	19	3.7
Never	1	0.2
Close friends nearby		
Yes	474	86.5
No	74	13.5
Close friends nearby to help with real problems		
Yes	385	74.5
No	132	25.5
Close friends nearby you can talk to about personal problems/fears/hopes		
Yes	333	64.9
No	180	35.9

TABLE 18--continued

Variables	Number	Percent
How often do you get together with close friends?		
Almost daily	124	25.9
Several times a week	161	33.7
Several times a month	127	26.6
Several times a year	27	5.6
Seldom	38	7.9
Never	1	0.2

The number of respondents seeking or receiving help from close relatives was 270 (52.8 percent). The number of close relatives that were asked assistance or provided help without being asked ranged from one to thirty. The average number of close relatives utilized by the respondents was nine during the past year.

The frequency of interaction between the sample and their close relatives shows that 195 (37.6 percent) reported "almost daily," 177 (34.2 percent) "several times a week," 101 (19.5 percent) "several times a month," 25 (4.8 percent) "several times a year," 19 (3.7 percent) "seldom," and only one (0.2 percent) stated "never."

Of the total sample, 474 respondents (86.5 percent) had close friends living nearby. The data shows that 385 respondents (74.5 percent) had close friends that could help with real problems and 333 respondents (64.9 percent) reported that they could talk with these friends

regarding their inner most personal problems, fears, or hopes. The data further shows that 124 respondents (25.9 percent) got together with close friends "almost daily," 161 (33.7 percent) "several times a week," 127 (26.6 percent) "several times a month," 38 (7.9 percent) "seldom," and one (0.2 percent) reported "never."

The highest utilizers of informal resources in the sample were young females (20-29), married respondents with at least a high school education. There were no apparent differences in utilization rate of informal resources among the household income levels to indicate which household income bracket was more incline to use informal resources. The respondents who generally under-utilize informal resources were males, the elderly (60+), those with an education beyond high school, and the widowed, separated, or divorced. The implications of these findings are elaborated upon in the following two sections.

Barriers to Utilization of Mental Health Services

The results presented thus far reveals three general characteristics of the respondents' relationships with formal health services and informal resources. They are as follows: (1) The respondents would most likely use

formal health services that are familiar to them, such as a medical doctor, regardless of the nature of their illness; (2) They generally reject or under utilize existing mental health services; and (3) The primary source of help among the respondents is their family system.

The problem of under utilization of mental health services is complex and difficult to resolve. It can be partially attributed to the institutional barriers imposed by the mental health establishment that are often beyond the control of the respondents. An in depth examination of these institutional barriers would be desirable; however, at this time, it is beyond the scope of this research project. Nonetheless, it is still possible to gain some helpful insights into the problem of low utilization of mental health services by analyzing the respondents' lack of awareness of the existence of a nearby community mental health center and their mental health help seeking preference.

In order for persons to utilize mental health services not only must they recognize that they have a mental health problem and be willing to seek help, but they must also have adequate information of where to go for assistance. The results shows that of the total sample, 185 respondents (33.8 percent) reported that they knew the location of a local community mental health

center; 363 respondents (66.2 percent) did not know the location.

The percentage that reported knowing the location of a local community mental health center may be inflated because it is suspected that some of the respondents may have been referring to the location of two nearby and well known state mental hospitals (Napa and Agnew State Hospitals). This confusion regarding the identification of appropriate facilities may stem from the fact that in Guam the community mental health center is located and operated under the aegis of the Guam Memorial Hospital. Since an overwhelming majority (89.4 percent) of the sample were born and reared in Guam, it is assumed that some of the respondents may have been operating on a reasonable preconceived notion that all community mental health centers are located in a hospital setting.

There is merit to the assumption that respondents would utilize mental health services if they were aware of the location of a community mental health center. However, this assumption is restricted because there may be some other cultural factors that prevents the utilization of mental health services, such as the respondents' preference to depend on their natural support networks.

Since earlier results have shown that Guamanian Americans do not utilize mental health services, it was assumed that there are other specific ways in which the

respondents were linked in their attempts to meet their mental health needs. In order to obtain such information, the respondents were asked to indicate to whom they would initially seek help from if he/she or any member of their family had an emotional or mental health related problem. The results of the respondents ranking preference for mental health assistance revealed the existence of a viable and functional indigenious support network.

The respondents ranked "relatives" first, which supports earlier findings that the family system is indeed their primary source of mutual aid and emotional support. Traditionally, the Guamanian American family is a multi-purpose system that directs its resources to the emotional and material well-being and success of its members from birth to death. A Guamanian American in need of emotional support, guidance, food, or money expects and is expected to turn to his/her family first in order to have such needs met.

A "priest" was ranked second, which reflects the church's subjective and enduring influence on the respondents. Although the Island of Guam is well equipped with a wide range of human and mental health services, the local people still utilize the village priest for their psycho-social problems. In 1980, the Catholic Church, under the directorship of a local village priest, created the first Catholic Social Services to meet some of the

social and personal problems that are not being effectively met by the government of Guam agencies.

"Friends" was ranked third by the respondents as a source of initial help with a mental health related problem. Guamanian Americans are typically gregarious and have a high regard for close friends. Close friends are often incorporated in the Guamanian American reference group or extended family. In the absence of a family system, Guamanian Americans often perceive and relate to close friends as surrogate family. In California this has been especially true since they often develop a common, social, and personal bond with their fellow immigrants from Guam. The concept of family is flexible and it often includes those close friends chosen to become Compadres or Comadres (Godfathers or Godmothers) for the Guamanian American children.

The respondents selected a "Community Mental Health Center" as their fourth preference for initial help with an emotional or mental health related problem. The data suggests that a Community Mental Health Center is not readily accepted or incorporated into the respondents' overall strategy for resolving mental health problems. Furthermore, it confirms the assumption that, in general, Guamanian Americans will seek mental health assistance only when a problem is perceived as serious, otherwise, they tend to deal with their problems within the extended

family system. While this reluctance may be due to the respondents' preference for mutual aid, it is also possible that mental health services are not perceived as being useful for their psycho-social problems.

The respondents ranked "seeking help from no one/self" as their last preference for help. Although the respondents did not prefer self help as a strategy for solving mental health related problems, the data does make subtle reference in support for the existence of a naturalistic belief that is quite common among Guamanian Americans. It should be noted that the naturalistic beliefs of Guamanian Americans are greatly influenced by religion. Basically, their naturalistic beliefs involve the idea that "Divine Providence" is involved in all aspects of their daily life. Therefore, one must faithfully accept both the good and the bad experiences because it is really beyond their control and it is the "Will of God."

On the surface this belief may seem fatalistic, but paradoxically such beliefs have often been a source of strength and consolation in times of need. A more down-to-earth explanation for the respondents to utilize self-help may stem from their belief that to admit mental health problems is a sign of weakness and failure that is best kept a secret. This belief often results in the pursuit of a "non solution" to their mental health problems.

Of the total sample, 401 respondents (73.2 percent) did not select a community mental health center as their first preference for help with an emotional or mental health related problem. Table 19 presents the respondents' reasons for not initially selecting a community mental health center. It should be noted that the respondents could cite more than one response for not seeking help from a community mental health center. Therefore, the response total does not agree with the number of respondents.

TABLE 19

REASONS CITED BY GUAMANIAN AMERICANS FOR NOT INITIALLY SEEKING HELP FROM A COMMUNITY MENTAL HEALTH CENTER

Reasons for not Seeking Help from a Community Mental Health Center	Number	Percent
Unaware of the existence of mental health services	170	32.4
Embarrassment	148	28.2
Fear	123	23.5
Financial	50	9.5
Language difficulties	21	4.0
Transportation problems	12	2.3
Total Responses	524	100.0

The three most frequently mentioned reasons (unaware of services, embarrassment, and fear) reflects not only the respondents' lack of awareness of the location and availability of mental health services, but also their apprehension about utilizing these services due to their subjective feelings and perceptions about mental health in general. The problem of not being aware of mental health services is commonly shared by most newly arrived immigrants, such as Guamanian Americans. Even if the Guamanian American decided to utilize these services, their lack of awareness of the availability and location of mental health services can effectively continue to discourage utilization. The resolution of this problem may not be a priority for the dominant members of the American society since they are probably more aware and in tune with mental health and other human services. However, for the newer and less sophisticated people of color, it becomes crucial since they are often confronted with daily problems in their new environment.

Increasing the respondents' awareness of the existence of a western, technologically oriented mental health service may possibly increase utilization, if and when they are in need of such services. However, the likelihood of this happening is minimal at best, because of other subjective values or reasons such as embarrassment,

fear, and culture that effectively deter seeking help from a community mental health center.

Not unlike other cultures in the Pacific, one of the most compelling cultural values of Guamanian Americans is the notion that one's capacity to control expression of personal problems or troubled feelings is a measure of maturity. To admit having an emotional or mental health related problem is viewed as a sign of weakness that often becomes a source of embarrassment to the person and his/her reference group.

Bringing shame, either intentionally or unintentionally, upon oneself or others is one of the most profound social violations for a Guamanian American. Thus, the Guamanian American may perceive mental health services as a shame-inducing process and will undergo extreme stress when asking or accepting professional help from anyone outside the family system.

The respondents' lack of awareness and embarrassment about seeking help from a community mental health center can be considered a by-product or extention of their fears, real or imagined, of the consequences that could befall upon them or their extended family. Other less frequently cited reasons that prevent the respondents from initially utilizing a community mental health center were financial, language barriers, and transportation problems. These barriers are less likely to deter utilization of mental

health services and are probably easier to overcome with the help of the respondents' indigenous mutual aid and family system.

CHAPTER VII

SUMMARY AND RECOMMENDATIONS

Summary

This research has examined various sociodemographic aspects of Guamanian Americans residing in Northern California, including such things as their natural helping networks and human service utilization patterns, in an effort to determine their level of mental health service needs.

The research was designed to indicate the level of mental health service needs of Guamanian Americans by utilizing indirect social indicators as they relate to the psychiatric symptom/dysfunction scale scores of the sample. The research design is limited in its ability to identify all of the human service needs or problems encountered by any given target population. However, the findings highlighted by this research are helpful in establishing a baseline profile of the general psychosocial well-being of the Guamanian American population.

The data collected in the course of this research profiles Guamanian Americans as young, recent immigrants with large families. In a typical household there is a likelihood that two or more adults may be employed

full-time. However, in spite of this situation, household median income appears to be slightly below that of the general population. Guamanian American educational attainment appears to be adequate for survival in California. However, underemployment seems to permeate much of the population and this prevents many persons from achieving a higher standard of living.

During the course of the research, it was found that a fair number of respondents who had been educated in Guam and are holders of advanced academic degrees, are employed in areas completely unrelated to their expertise--sometimes at unskilled or semi-skilled jobs. This situation can be partially attributed to transitional and/or economic difficulties one experiences as an immigrant. These difficulties often forces the immigrant to accept any employment opportunity for the sake of survival.

Guamanian Americans, as a group, are modest and proud of their ethnic heritage and have quietly established themselves in American society through hard work. Furthermore, Guamanian Americans have made an accommodation to western ideas and values while still maintaining their own self and group identity. Accommodation is viewed by many Guamanian Americans as necessary since "traditional" ways have proven ineffective, especially in coping with stress found here in America. The Guamanian American accommodation may be described as a function of their split

level psycho-social pattern of thoughts and behaviors that allows the Guamanian American to function in a pluralistic society. In their quest to survive by accommodation Guamanian Americans have had to modify some traditional patterns of beliefs and behaviors in order to capitalize on opportunities accorded by the mainstream society.

Although Guamanian Americans can be considered westernized, they are still demonstrably bi-cultural. Their approach to problem solving and their participation in larger social settings indicates their general preference to interact or socialize with their Guamanian American peers. Munoz's (1979) study on the westernization of Guamanian Americans was not conclusive, however, she suggests that Guamanian Americans tend to isolate their social/cultural lives from the community at large and expose or present only those aspects that produce no cultural conflict.[1]

In the preceeding chapter, it was suggested that the extrapolated rates of mental health service needs (low, moderate, and high) could be matched with existing services or programs provided by a community mental health center. For example, individuals falling in the low need category could benefit from consultation

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[1]Faye U. Munoz, "An Exploratory Study of Island Migration: Chamorros of Guam," (D.S.W. Dissertation, University of California, Los Angeles, 1979).

and education programs; those in the moderate need group were classified as being in probable need for more direct mental health services such as outpatient programs, and those who were in the high need category were considered to be highly symptomatic and dysfunctional and thereby could benefit from a more intense form of mental health care. However, such care should not be limited to traditional inpatient services unless there is an immediate threat to self or others.

The suggestion of matching needs with mental health services may appear simplistic and arbitrary, however, the matching process is not so inadequate. The matching process should be viewed as taking the first step toward a time when institutional changes can be made that would offer other less conventional and more culturally sensitive mental health programs that will be conducive to the behavioral styles and needs of minorities.

The following demographic characteristics were found to be associated with high levels of mental health problems and can be viewed as high-risk factors for estimating the level of mental health service needs for Guamanian Americans:

1. Mental health service needs are related to age and sex. Reported rates are lowest for the young, varied among the aged, high for the middle age, and high for females.

2. Low socioeconomic status (low household income) and low educational attainment are significantly associated with mental health problems.

3. A higher incidence of mental health service needs was found among those persons who were divorced, separated, or widowed than among those persons who were married.

It is conjectured that the estimated rates of mental health service needs reflects the broad social forces or life stressors at work which determines the life changes and life situation of Guamanian Americans.

In an effort to evaluate whether or not any of the County Community Mental Health Centers have programs that addresses itself to the psycho-social needs of Pacific Islanders, the researcher reviewed each county's annual plan, five year plan, budget documents for fiscal year 1980-1981, and annual reports. Interviews with program planners were also conducted and while interviews were cursory they did give a view of the county's attempts to serve the general community.

The net result of this review shows that, in general, the counties have basically met all the requirements mandated by law, but specific programs for Pacific Islanders were limited or non-existent in Northern California. None of the Community Mental Health Centers within the research area utilized specific ethnic descriptors for the different groups of people within

the Pacific area who have migrated to Northern California. The specific ethnic identification for Guamanian Americans or other Pacific Islanders, such as Samoans, Tongans, Palauans, etc. was lacking and therefore could be classified under the ethnic descriptor "Asian," "Pacific Islanders," "Other," "Non-white Other," and "Asian Other," thus absorbing the Guamanian American population into categories from which it would be difficult to break out a specific ethnic group. There was no consistency of reporting among Community Mental Health Centers.

The problem of ethnic descriptors or classifications have created a lack of sufficient systematic data that could assess the extent to which Guamanian Americans in Northern California utilize mental health services. The findings of this research indicate a serious under-utilization of mental health services by Guamanian Americans.

In terms of assessing actual utilization patterns of mental health services, the sample population were asked to report their utilization of various human service providers or facilities. The results clearly established the fact that Guamanian Americans are under-utilizers of mental health services in Northern California. By contrast, the sample population had a disproportionately high utilization rate of physical health care, in particular, the use of physicians and hospitals. The effects of

psychological problems on the physical condition of individuals have been recognized by both the medical and mental health profession. A strong case for the researcher's speculation that Guamanian Americans are utilizing medical services for some of their mental health problems can be made by just reviewing the general population's use of prescription medication and over-the-counter drugs in their efforts to alleviate stress or other psychological problems that have manifested themselves into physical symptoms.

Notwithstanding the lack of precise documentation to provide evidence or support for the above contention, the research attempted to identify specific ways in which Guamanian Americans were linked in their attempt to meet their psychological needs. Of particular interest was their natural and informal helping networks.

The research findings, relative to utilization of mental health services and informal resources have consistently indicated that Guamanian Americans are generally reluctant to approach current mental health programs for intervention. Furthermore, the results support the contention that among Guamanian Americans the primary source of psycho-social support and mutual aid is their family system, which is their first line of defense or assistant in dealing with daily problems imposed by their new and often complex environment.

Family and ethnic cohesion is strong among Guamanian Americans and often serves as a social cushion or mitigating agent against external negative forces beyond their control. While mutual aid is commendable, it should be recognized that it does have limitations and drawbacks in meeting all of the group's needs for survival in California. For example, a heavy reliance on the family or voluntary support networks limits one's ability to generate new resources to meet one's needs which can cause more problems, such as depleting the kinship's socioeconomic resources and opportunities to advance or succeed in their new environment.

In assessing the Guamanian American experience, it would appear that their low mental health service utilization rate may be attributed to their lack of knowledge of the availability of mental health programs in their neighborhood and also to certain cultural values and practices. The research has now documented that a large majority of Guamanian Americans are not familiar with the location of a local Community Mental Health Center. Furthermore, Guamanian Americans are apprehensive about utilizing current mental health services due to barriers subjectively perceived by them. Not surprisingly, one of the most frequently cited reasons to account for their under-utilization of mental health services is the concept of shame or their subjective feelings of embarrassment.

The concept of shame is prominent in the Guamanian American culture and as such they will undergo extreme stress or illness before seeking mental health assistance. It may be surmised, therefore, that among Guamanian Americans, mental illness or problems are less likely to receive attention not only because of cultural resistance and collective tolerance but also because of their lack of knowledge or awareness of the community mental health resources.

Recommendations

Guamanian Americans, as well as other Pacific Islanders, have immigrated to the United States in increasing numbers during the past decade but yet there is virtually nothing known about their needs or the extent to which human and mental health services are effective in ameliorating their psycho-social problems. As a result, Pacific Islanders are under-served or provided inferior services that will not be utilized because they are either inappropriate or ineffective in reaching those in dire need of assistance.

The difficulties in correcting this situation is not only limited to the cultural preferences or practices of Guamanian Americans but also includes the popular stereotype placed on Pacific Islanders that they are "carefree," "exotic," and/or a "model close knit minority" that takes

care of its members. This stereotype, although flattering, is damaging to the degree that it diverts public attention and resources from actual problems which exists within the Guamanian American communities.

As Pacific Islanders become more aware of their needs and the resources that are available in the community, there will be an increase in human service demand. At a time of high inflation and the trend towards less funding for human services, the demand on local agencies to document the need for services they provide in a cost effective fashion will be greater and more restrictive in the planning for alternative programs that would be beneficial to minority groups.

In light of this trend and the likelihood that minority people of color will be affected the most, the need for documentation of service needs as well as documentation of the relative effectiveness of existing human services becomes of paramount concern if there is to be equitable attention and concern given to Pacific Islanders in America.

Therefore, the basic strategy implied in the researcher's recommendations involves strengthening the interface between the mental health service delivery system and the Guamanian American population, rather than a major restructuring of programs or delivery modes.

The research findings sets up the parameters for the following recommendations:

1. Based on the research finding that one of the most vulnerable segments of the Guamanian American community are women who are either divorced, separated, or widowed with low sociodemographic status, the researcher recommends: That this pre-targeted group be made a priority in any subsequent treatment program or out-reach activity being developed on Federal, state, or county level with regards to providing health and mental health services.

2. Based on the research finding that the family network is the primary source of mutual aid and support for Guamanian Americans, the researcher recommends: That mental health service providers should incorporate an extended family perspective in the care and treatment of troubled Guamanian Americans. In other words, any psychotherapeutic intervention with Guamanian Americans should incorporate, as a significant part of the diagnostic, treatment, and follow up process, an understanding of the dynamics involved in the extended family system. For example, interventions such as family therapy, if conducted within the cultural patterns or framework of the Guamanian American network, can be a viable treatment modality. Therapists working with Guamanian American families should take into consideration significant extended family members, recognizing that relatives other than the nuclear

family may often be relevant in the alleviation of mental health problems. Furthermore, therapists should be prepared to expect cultural variations and behavioral styles that may be different from their own family experiences.

Achieving an extended family perspective enhances the mental health service providers' ability to become more aware and sensitive to the psycho-social needs of Guamanian Americans, since the family system is the corner stone of their culture.

3. Based on the research findings that Guamanian Americans under-utilize mental health services because of barriers associated with their lack of knowledge, embarrassment, and fear of such services, the researcher recommends: That present mental health service delivery systems improve their image and accessibility to Guamanian Americans and other Pacific Islanders. In other words, mental health services and facilities should be made conducive to the cultural styles and needs of Guamanian Americans. This recommendation could easily be implemented by accomplishing the following tasks:

a. Mental health services should develop and disseminate culturally relevant information concerning mental health education and care.

b. Mental health services should tap into existing networks of indigenous natural helpers, informal

organizations of friends and relatives in the Guamanian American communities. Once linkage has been established between mental health services and the Guamanian American communities, serious consideration should be given to the training and inclusion of bilingual/bicultural natural helpers into the mental health service delivery system. Natural helpers with some training and support from both the Guamanian American communities and the mental health service delivery system could become involved in mental health prevention programs, outreach/referral services, and direct services such as crisis intervention and supportive counseling.

4. Based on the research finding that most counties in Northern California have a community based Guamanian American organization, the researcher recommends: That health and mental health service providers should support and encourage these organizations to participate in the planning, development, and implementation of advocacy activities and/or outreach programs.

5. The research effort was largely dependent on using indirect social indicators and psychiatric symptom/dysfunction criteria to measure levels of mental health service needs and since this approach is a first time effort with Guamanian Americans the researcher recommends: That the research results be compared with other data that have been collected from similar test

instruments in order to have a cross-cultural comparison relative to levels of mental health service needs among different ethnic groups.

6. In preparing the final statement it occurred to the researcher that no reference, overt or covert, was made in the context of the interview schedule to elicit information with regards to other human service needs or social problems that are currently being unmet. Not knowing the full range of psycho/social/economic problems of Guamanian Americans the researcher recommends: That further study be made to collect and document other human service needs of Guamanian Americans. Furthermore, a more in depth analysis of the effectiveness of the human service and/or mental health service delivery systems in meeting the general psycho-social needs of Guamanian Americans must be initiated in order to match needs and services in a cost effective manner.

Conclusion

In the introduction, it was pointed out that in spite of heightened awareness for civil rights and advocacy activities for minorities, Pacific Islanders have yet to be recognized or related to as a full participant in the mainstream society. Consequently, their human service needs are largely unknown and/or neglected by Federal,

state, and local health, mental health, and human service delivery systems.

This research has documented levels of mental health service needs and has identified several target subgroups within the Guamanian American communities that are most vulnerable to mental health problems. Furthermore, the research revealed that Guamanian Americans are not utilizing traditional mental health services because of factors related to their social and cultural background. However, such factors are not the only reasons for under-utilization of mental health services. To a large extent, the problem of under-utilization can be linked to institutional policies and bureaucratic practices that promote western oriented and standardized conventional approaches to the delivery of mental health services.

The continued reliance of such approaches to serve minority people of color has been largely inappropriate and ineffective because they are often in conflict with non-western cultures and approaches to mental health problems. For example, Guamanian Americans as well as other ethnic minorities simply do not fit into the well-known profile of the young, attractive, verbal, intelligent, and successful client (YAVIS) who is considered by most mental health practitioners as the best candidate for traditional mental health services. Furthermore, Guamanian Americans do not fit nor share fully the

contemporary values of independence (versus interdependence), individualism (versus familism or groupism), and nuclear family (versus extended families).

Developing culturally appropriate mental health services within a system funded by Federal, state, and/or county government raises issues of preference, bias, racism, and culture as well as questions suggesting that funds be allocated to programs that will benefit the largest number of people at the least amount of cost, as mandated by law. However, when we are confronted with a significant minority population within a catchment area whose needs are not being met by conventional mental health services, it can be assumed that they are being either consciously or unconsciously discriminated by the general nature of the law.

This is not to say or guarantee that minority residents, such as Guamanians, will fully utilize mental health services. While mental health services may be culturally appropriate and accessible, there still may be resistance on the part of the potential user. The question of resistance is best addressed by developing a program of outreach and education, which was earlier suggested by the researcher.

If Guamanian Americans can be considered a reasonable example of how Pacific Island people cope with their mental health needs, then the issue of delivery of mental health

services on an equal basis, as mandated by law, must carefully be reevaluated by both the mental health service providers/planners and the Pacific Island groups.

The reality of such a joint venture is pessimistically viewed by the researcher at this time because Pacific Islanders have yet to reach similar levels of activism as have other minority groups, on the one hand, and, also, because Pacific Islanders are not numerically large or politically powerful to influence and/or demand culturally relevant mental health services in this democratic society, on the other. Therefore, it is not surprising to know that the mental health needs of Pacific Islanders are often bypassed.

Although I have suggested a dismal future in terms of bridging the widening gap between the mental health service delivery system and ourselves, we should not deter nor resign from aggressively (although we are not socialized to be aggressive) pursuing the goal of mustering support for our needs, concerns, and problems in America. Guamanian Americans should begin to learn the political realities attached to all aspects of human service systems affecting their lives and start revitalizing old alliances with other Pacific/Asian Americans as well as form new ones. Only by having a unified front and support from other larger minority groups can Pacific Islanders begin to realize their full potential of impacting the American democratic system to be more responsive to their needs.

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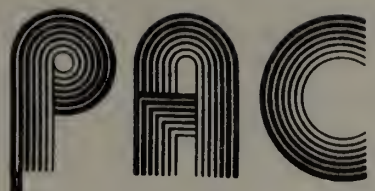
APPENDICES

APPENDIX A

PRESS RELEASE



PRESS RELEASE

PACIFIC/ASIAN COALITION

PACIFIC ASIAN RESEARCH PROJECT

THE NATIONAL COALITION OF ASIAN AMERICANS AND PACIFIC ISLAND PEOPLES FOR HUMAN SERVICES AND ACTION

The Pacific Asian Coalition (PAC), a non-profit National Human Service Advocacy and Research Organization, located at 1366 Tenth Avenue, San Francisco, California is planning to undertake a major survey of Guamanian health needs. The initial phases of this study will be conducted in Santa Clara and Alameda Counties. Mr. David Leon Guerrero Shimizu, a Guamanian doctoral candidate at the University of Massachusetts, has the primary responsibility for this project.

The need for reliable health information on Guamanians has prompted the Pacific Asian Coalition to develop this research component. It is hoped that wide spread participation will result in reliable and significant information being collected. Mr. Shimizu is working very closely with various individuals in the Guamanian community in order to develop appropriate contacts for his study. Mr. Shimizu will be collecting his information by using telephone interviews. He will be interested in speaking with Guamanians over the age of eighteen living in Santa Clara and Alameda Counties. It is anticipated that this survey will take approximately half an hour to complete. Present plans call for five hundred subjects to participate in his initial survey research. All information collected in the course of this study will be kept confidential.

A summary of the information from this study will be critical in developing Federal, State, and Local human service programs for Guamanians and other Asian and Pacific Island groups. Mr. Shimizu will be contacting individuals throughout this time. If you are interested in contributing your ideas, and wish to become part of this study, please contact Mr. Shimizu at the following address:

323 Blossom Hill Road, #3
San Jose, CA 95123

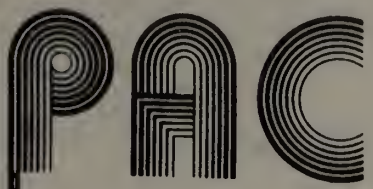
(408) 224-9082

1366 Tenth Avenue
San Francisco, CA 94122

(415) 665-6006

APPENDIX B

PERSONAL LETTER TO GUAMANIAN AMERICAN HOUSEHOLDS



PACIFIC/ASIAN COALITION

PACIFIC ASIAN RESEARCH PROJECT

THE NATIONAL COALITION OF ASIAN AMERICANS AND PACIFIC ISLAND PEOPLES FOR HUMAN SERVICES AND ACTION

HAFA ADAI,

My name is David Leon Guerrero Shimizu. I am with the Pacific Asian Coalition, a non-profit National Human Service Advocacy and Research Organization. I am conducting a research to determine the health needs of our fellow Guamanians living in Santa Clara and Alameda Counties.

This research will be part of my doctoral dissertation as well as part of a nation-wide needs assessment project that is concerned with Pacific Islanders and Asian living in the United States.

Currently there is a lack of reliable information regarding our health needs that could be of assistance to health planners in developing appropriate health programs for us on Federal, State and Local levels.

In an effort to document our needs, I am asking for your kind cooperation to allow yourself and other family members over the age of eighteen to take part in this research.

I will be interviewing approximately five hundred Guamaninas, asking information on what you believe your health needs to be. All information collected in the course of this study will be kept confidential. No individual who participates in this study will be identified in anyway. Interviews will be conducted by telephone.

Should you have any questions regarding this research, please feel free to call me at: (408) 224-9082, and I will try my best to answer them.

SI YUUS MAASE,

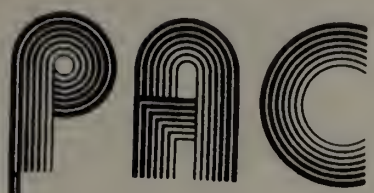
David Leon Guerrero Shimizu

DLGS/aw

323 BLOSSOM HILL ROAD, #3 * SAN JOSE * CA * 95123 * (408) 224-9082

APPENDIX C

APPRECIATION LETTER TO RESEARCH RESPONDENTS



PACIFIC/ASIAN COALITION

PACIFIC ASIAN RESEARCH PROJECT

THE NATIONAL COALITION OF ASIAN AMERICANS AND PACIFIC ISLAND PEOPLES FOR HUMAN SERVICES AND ACTION

HAFA ADAI,

On behalf of the Pacific Asian Coalition and the Interviewers, I would like to extend our sincerest SI YUUS MAASE to you for participating in our interviews.

Your help truely reflects the spirit of the Chamorro people who are known to be hospitable and generous to anyone seeking their help. This research would not have been possible without the support and cooperation from people like you.

The wide response from our community was beyond all expectation and will be instrumental in obtaining reliable and significant information that could be of assistance to health planners in developing appropriate health programs for us on Federal, State and Local levels.

The value of your help can not be measured in terms of money, however it is my sincere desire that the research will contribute to a better understanding of our health needs and assist others who are interested in our well being here in California.

Enclosed you will find a Guam Sticker as a small token of our appreciation.

SI YUUS MAASE,

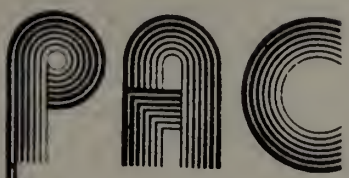
David Leon Guerrero Shimizu

DLGS/sw

323 BLOSSOM HILL ROAD, #3 * SAN JOSE * CA * 95123 * (408) 224-9082

APPENDIX D

INTRODUCTORY AND CLOSING GUIDES FOR THE INTERVIEWERS



PACIFIC/ASIAN COALITION

PACIFIC ASIAN RESEARCH PROJECT

INTRODUCTORY STATEMENT

Good afternoon/evening. Is this the (name of the potential respondent) residence?

My name is _____, and I am an interviewer with the Pacific Asian Coalition. We are conducting a research under the supervision of Mr. David L. G. Shimizu to determine the level of mental health service needs of our fellow Guamanians living in the Bay Area.

We would like to ask your help by allowing me to interview you and other family members over the age of eighteen years. We feel that your participation will give us an accurate picture of our mental health and health service needs.

The interview will be conducted through the telephone and takes only twenty minutes to complete. All information that you give will be held in the strictest of confidence. No individual who participates in this study will be identified in any way.

You are free to not answer any or all of the interview questions and can ask me any questions at any time during the interview. Do you have any questions before we begin?

CLOSING STATEMENT

Mr/Mrs/Name of respondent, I want to thank you for taking the time to help us and again the information you gave will be held in the strictest of confidence.

Now that we are finished, is there any other family member over the age of eighteen years that would like to participate in this research?

* If qualified persons are not home, ask the respondent if it will be all right to call back again to talk with the other qualified family member.

* If the qualified person(s) is home, ask for their names and further ask permission to speak to him/her.

* When another qualified person comes to the telephone, repeat the introductory statement.

THE NATIONAL COALITION OF ASIAN AMERICANS AND PACIFIC ISLAND PEOPLES FOR HUMAN SERVICES AND ACTION

323 BLOSSOM HILL ROAD, #3 * SAN JOSE * CA * 95123 * (408) 224-9082

APPENDIX E

INTERVIEW SCHEDULE

Attach address label

( ) -

area code Phone number

ID # _____

Interviewer: _____

Date of Interview:

_____

Time Start: _____

Time Finish: _____

It is important that scale items be read verbatim. For example, an interviewer asking question #39 would say:

"Do you tend to feel tired in the mornings? Would you say: Often, Sometimes, or Never?"

The interviewer would then circle the respondent's answer (far right column) prior to transferring the equivalent score to the coding column. This is particularly important if the respondent cannot or does not answer the question. Otherwise, a zero score, by itself, could represent a "NEVER" or a missing value, with no distinction made.

Interview reviewed by:

ID #_____

		(Coding)	
1. WHAT IS YOUR ETHNIC HERITAGE?		___ ___	1 Guamanian 2 Asian/Pacific Islander 3 Other _____ 97 Don't know 98 Not answered
2. SEX		___ ___	1 Male 2 Female
3. WHAT WAS YOUR AGE ON YOUR LAST BIRTHDAY?		___ ___	_____ (AGE GIVEN) 97 Don't know 98 Not answered
4. IN WHAT COUNTRY WERE YOU BORN?		___ ___	1 USA 2 Guam 3 Other: SPECIFY _____ (country) 97 Don't know 98 Not answered
5. IF NOT BORN IN THE USA, How many years have you lived in the USA?		___ ___	_____ years 00 under 1 year 97 Don't know 98 Not answered
6. HOW MANY YEARS OF SCHOOL HAVE YOU COMPLETED? (highest grade completed)		___ ___	_____ years 97 Don't know 98 Not answered 99 Not applicable
7. WHAT IS YOUR PRESENT MARITAL STATUS? IF NOT MARRIED SKIP TO Q. 10.		___ ___	01 Single 02 Married 03 Widowed 04 Separated 05 Divorced 06 Common Law 07 Other: _____ 97 Don't know 98 Not answered

8. IF MARRIED, IN WHAT COUNTRY WAS YOUR SPOUSE BORN?		___ ___	01 USA 02 Guam 03 Other: SPECIFY _____ (country) 97 Don't know 98 Not answered 99 Not applicable
9. HOW MANY YEARS OF SCHOOL HAS YOUR SPOUSE COMPLETED? (highest grade completed)		___ ___	___ years 97 Don't know 98 Not answered 99 Not applicable
10. IS ANY LANGUAGE OTHER THAN ENGLISH SPOKEN IN YOUR HOUSEHOLD?		___ ___	00 No 01 Chamorro 02 Other: SPECIFY _____ 97 Don't know 98 Not answered
11. ARE YOU A MEMBER OF ANY ORGANIZATIONS?		___ ___	1 yes 2 no SKIP TO Q. 12
11a. WHAT ARE THE NAMES OF THE ORGANIZATIONS YOU BELONG TO?		___ ___	_____ _____ _____ _____ _____
12. WHEN WAS THE LAST TIME YOU VISITED GUAM?		___ ___	19__ 99 Never returned
13. HOW OFTEN DO YOU VISIT GUAM?		___ ___	_____

14.	ARE YOU PRESENTLY EMPLOYED? (READ CHOICES)		___ ___	1 Full time: 30+ hours SKIP TO Q.18 2 Part time 3 Unemployed 4 Homemaker, housewife 5 Student 6 Retired 97 DK 98 REF 99 NA
15.	ARE YOU EMPLOYED LESS THAN FULL TIME BECAUSE OF ONE OF THE FOLLOWING REASONS:		___ ___	01 Retired 02 Seasonal worker 03 Fired or laid off 04 Going to school 05 Have children at home 06 Pregnancy 07 Unable to find suitable work 08 Disabled ASK Q.16 09 Other: PLEASE SPECIFY _____ 97 DK 98 REF 99 NA
	ASK ONLY IF DISABLED, OTHERWISE GO TO Q.18 16. IS YOUR DISABILITY:		___ ___	1 Temporary 2 Permanent 97 DK 98 REF 99 NA
17.	IS YOUR DISABILITY DUE TO A PHYSICAL OR MENTAL HEALTH PROBLEM?		___ ___	1 Physical health 2 Mental health 97 DK 98 REF 99 NA

18. HOW MANY DAYS DURING THE LAST 12 MONTHS WERE YOU UNABLE TO DO YOUR USUAL WORK BECAUSE OF A PHYSICAL HEALTH PROBLEM? INCLUDES HOUSEWIFE OR STUDENT		— —	____days 00 none 96 96 days or more 97 DK 98 REF 99 NA
19. HOW MANY DAYS DURING THE LAST 12 MONTHS WERE YOU UNABLE TO DO YOUR USUAL WORK BECAUSE OF A MENTAL HEALTH PROBLEM? INCLUDES HOUSEWIFE OR STUDENT		— —	____days 00 none 96 96 days or more 97 DK 98 REF 99 NA
20a. WHAT DO YOU CONSIDER YOUR MAIN JOB OR OCCUPATION? JOB TITLE OR NAME: IF HOUSEWIFE, RETIRED OR DISABLED, SKIP TO Q. 22.		— —	_____
20b. WHAT ARE SOME OF YOUR MAIN DUTIES OR ACTIVITIES? PROBE:		— —	_____ _____ _____ _____

20c. WHAT KIND OF BUSINESS OR INDUSTRY DO YOU WORK IN? PROBE:		___ ___	_____
21. IS THIS YOUR OWN BUSINESS?		___ ___	1 Yes 2 No 98 REF 99 NA
22. HOW MANY PEOPLE IN YOUR HOUSEHOLD ARE USUALLY EMPLOYED AT LEAST HALF-TIME (ABOUT 20 HRS. A WEEK)?		___ ___	Number 0 None 97 DK 98 REF 99 NA

THIS NEXT QUESTION IS VERY IMPORTANT FOR THE STUDY.

23. WHAT WAS THE APPROXIMATE TOTAL INCOME OF YOUR HOUSEHOLD FOR 1979? THIS FIGURE SHOULD INCLUDE ALL WAGES AND SALARIES, BUSINESS PROFITS, NET FARM INCOME, PENSIONS, SOCIAL SECURITY, RENTS, AND ANY OTHER INCOME RECEIVED BY IMMEDIATE MEMBERS OF THE FAMILY BEFORE TAXES.

PROBE:

#1 FOR INCOME LESS THAN $3,500, TRY TO NARROW DOWN TO ACTUAL NEAREST $100.

#2 FOR INCOME $3,500 - $15,000 TRY TO NARROW DOWN TO ACTUAL NEAREST $500.

____ ☐ $/a year before taxes

____ ☐ after taxes

OR

☐ $/a month before taxes

____ ☐ after taxes for ____ months

OR

☐ $/a week before taxes

____ ☐ after taxes for ____ weeks

IF RESPONDENT HESITATES, SAY:

Let me read some income blocks. Stop me when I come to one that is most appropriate for your total annual household income:

1.	under - $ 3,500	PROBE #1
2.	$ 3,500 - $ 5,000	
3.	$ 5,700 - $ 7,000	PROBE #2
4.	$ 7,000 - $10,000	
5.	$10,000 - $15,000	
6.	$15,000 - $20,000	
7.	$20,000 - $25,000	WRITE IN
8.	$25,000 - $30,000	
9.	$30,000 - $40,000	$_____
10.	$40,000 - $50,000	
11.	over $50,000	before taxes ☐
97	DK	
98	REF	after taxes ☐
99	NA	

IF RESPONDENT STILL IS UNWILLING TO GIVE INCOME, READ:

We appreciate that some people consider this question very personal. It is, though, a very important one for the study. Your answer is confidential and anonymous. We would very much appreciate your answering the question.

IF STILL A REFUSAL, THEN READ:

Thank you, anyway. We certainly respect your wishes on this question.

24. Now I am going to read a list of people to you. Have you gone to any of the following during the last 12 months?

	Yes	no	DK	REF	NA
a doctor	1	2	7	8	9
a dentist	1	2	7	8	9
a chiropractor	1	2	7	8	9
a psychiatrist	1	2	7	8	9
a psychologist	1	2	7	8	9
a social worker	1	2	7	8	9
a family counselor (OTHER THAN ANY ABOVE . . .	1	2	7	8	9

24. continued

	yes	no	DK	REF	NA
a public health nurse	1	2	7	8	9
a minister, priest, rabbi, or any other religious person for counseling (OTHER THAN ANY BELOW)	1	2	7	8	9
a spiritualist, psychic	1	2	7	8	9
a natural healer, herbalist, surahana, surahanu, or someone like that, whom you have gone to for help?	1	2	7	8	9

25. If you have visited a surahanu/a, would you please give us his/her name, address and phone number.

Name: _____

Address: _____ City: _____

Phone Number: ( ) _____

26. I am going to read a list of health agencies. Have you gone to any of the following during the past 12 months?

	yes	no	DK	REF	NA
An Emergency room at a hospital?	1	2	7	8	9
A Community Mental Health Center?	1	2	7	8	9
Some other Mental Health Facility?	1	2	7	8	9
An Alcoholism Treatment Clinic?	1	2	7	8	9
A Drug Abuse Treatment Clinic?	1	2	7	8	9
A Vocational Rehabilitation Center?	1	2	7	8	9
A Health Department Clinic?	1	2	7	8	9

---

27. DO YOU (AND YOUR HUSBAND/WIFE) HAVE CLOSE RELATIVES NEARBY? ___ ___

*1 Yes
2 No SKIP TO Q.28.
97 Don't know
98 Not answered
99 Not applicable

27a. IF YES, HOW OFTEN DO YOU GET TO SEE THEM OR TALK TO ANY OF THEM? (Telephone included) ___ ___

1 Almost every day
2 Several times a week
3 Several times a month
4 Several times a year

27a. continued		5 Seldom 6 Never 97 Don't know 98 Not answered 99 Not applicable (relative living in household)
27b. IF YES TO 27, IF YOU HAD A REAL PROBLEM, DO YOU FEEL THAT YOU COULD CALL ON ANY OF THESE RELATIVES FOR HELP?	___ ___	*1 Yes 2 No 97 Don't know 98 Not answered 99 Not applicable
27c. DURING THE PAST 12 MONTHS HOW MANY OF THESE RELATIVES HAVE YOU GONE TO ASKING FOR ANY KIND OF HELP YOU CONSIDER IMPORTANT OR WHO HAS GIVEN YOU SUCH HELP WITHOUT YOUR ASKING FOR IT.	___ ___	Number 00 None 97 DK 98 REF 99 NA
28. DO YOU HAVE ANY CLOSE FRIENDS NEARBY?	___ ___	*1 Yes 2 No 97 Don't know 98 Not answered 99 Not applicable
28a. IF YES, HOW OFTEN DO YOU GET TOGETHER WITH THEM?	___ ___	1 Almost every day 2 Several times a week 3 Several times a month 4 Several times a year 5 Seldom 6 Never 97 Don't know 98 Not answered 99 Not applicable-(friends living in household)

29. DO YOU HAVE FRIENDS NEARBY WITH WHOM YOU CAN TALK ABOUT YOUR MOST PERSONAL PROBLEMS, FEARS, OR HOPE?		___ ___	1 Yes 2 No 97 Don't know 98 Not answered 99 Not applicable
30. DO YOU HAVE ANY CLOSE FRIENDS NEARBY TO HELP YOU WHEN YOU HAVE REAL PROBLEMS?		___ ___	1 Yes 2 No 97 Don't know 98 Not answered 99 Not applicable

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR HEALTH.

31. IN GENERAL, WOULD YOU SAY THAT YOUR PHYSICAL HEALTH HAS BEEN:		___ ___	1 Excellent 2 Good 3 Fair 4 Poor 5 Very bad 97 Don't know 98 Not answered 99 Not applicable

32. DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

1 Yes 2 No

a. CANCER	_____	f. HIGH BLOOD PRESSURE	_____
b. KIDNEY PROBLEM	_____	g. LITICO	_____
c. OVERWEIGHT	_____	h. TB	_____
d. NERVOUSNESS	_____	i. ASTHMA	_____
e. BODIC	_____	j. OTHER: SPECIFY _____	

33. HAS ANY MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING HEALTH CONDITIONS?

1 Yes 2 No

a. CANCER	_____	f. HIGH BLOOD PRESSURE	_____
b. KIDNEY PROBLEM	_____	g. LITICO	_____
c. OVERWEIGHT	_____	h. TB	_____
d. NERVOUSNESS	_____	i. ASTHMA	_____
e. BODIC	_____	j. OTHER: SPECIFY _____	

34. DO YOU HAVE ANY OTHER PHYSICAL OR HEALTH PROBLEMS AT PRESENT?		__ __	*1 Yes 2 No 97 Don't know 98 Not answered 99 Not applicable
34a. IF YES, WHAT ARE THEY? _____ _____ _____		__ __ __ __ __ __	(Code in office from International Classification of Diseases) __ __ __ __ __ __ __ __ __ 997 Don't know 998 Not answered 999 Not applicable
35. HOW WOULD YOU COMPARE YOUR HEALTH WITH ONE YEAR AGO? WOULD YOU SAY:		__ __	1 Same 2 Better 3 Worse 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 36. DO YOUR HANDS EVER TREMBLE ENOUGH TO BOTHER YOU? WOULD YOU SAY:		__	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable

ANX HOS 37. ARE YOU EVER TROUBLED BY YOUR HANDS OR FEET SWEATING SO THAT THEY FEEL DAMP AND CLAMMY? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 38. HAVE YOU EVER BEEN BOTHERED BY YOUR HEART BEATING HARD? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP HOS 39. DO YOU TEND TO FEEL TIRED IN THE MORNINGS? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP HOS 40. DO YOU HAVE ANY TROUBLE GETTING TO SLEEP AND STAYING ASLEEP? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable

ANX HOS 41. HAVE YOU EVER BEEN TROUBLED BY "COLD SWEATS?" WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP ANX HOS 42. DO YOU FEEL THAT YOU ARE BOTHERED BY ALL SORTS (DIFFERENT KINDS) OF AILMENTS IN DIFFERENT PARTS OF YOUR BODY? WOULD YOU SAY?		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP ANX HOS 43. DO YOU EVER HAVE LOSS OF APPETITE? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 44. HAS ANY ILL HEALTH AFFECTED THE AMOUNT OF WORK (HOUSEWORK) YOU DO? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable

ANX HOS 45. DO YOU EVER FEEL WEAK ALL OVER? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 46. DO YOU EVER HAVE SPELLS OF DIZZINESS? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 47. HAVE YOU EVER BEEN BOTHERED BY SHORTNESS OF BREATH WHEN YOU WERE NOT EXERTING YOURSELF? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
ANX HOS 48. FOR THE MOST PART, DO YOU FEEL HEALTHY ENOUGH TO CARRY OUT THE THINGS THAT YOU WOULD LIKE TO DO? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable

DEP HOS 49. DO YOU FEEL IN GOOD SPIRITS? WOULD YOU SAY:		___	0 Most of the time 2 Sometimes 4 Very few times 7 Don't know 8 Not answered 9 Not applicable
DEP HOS 50. DO YOU SOMETIMES WONDER IF ANYTHING IS WORTHWHILE ANYMORE? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 51. DURING THE LAST YEAR DID WORRY OR NERVOUSNESS GET YOU DOWN PHYSICALLY? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 52. DURING THE LAST YEAR, DID WORRY OR NERVOUSNESS CAUSE PROBLEMS WITH YOUR FAMILY LIFE? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

PSYDYS 53. DURING THE LAST YEAR, DID WORRY OR NERVOUSNESS INTERFERE WITH YOUR SOCIAL ACTIVITIES? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 54. DURING THE LAST YEAR, HAVE YOU EVER HAD TO STAY AT HOME OR IN BED BECAUSE OF WORRY OR NERVOUSNESS? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 55. DURING THE LAST YEAR, WERE YOU UNABLE TO DO YOUR USUAL WORK BECAUSE OF NERVOUSNESS OR WORRY? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 56. IN THE LAST YEAR, HOW OFTEN DID YOU FEEL THAT YOU MIGHT HAVE A NERVOUS BREAKDOWN OR THAT YOU MIGHT LOSE YOUR MIND? WOULD YOU SAY: (Don't read "NEVER")		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

INTERVIEWER'S INSTRUCTIONS:

If respondent volunteers NEVER, go to QUESTION 62 .

PSYDYS 57. DOES THIS FEELING GET YOU DOWN PHYSICALLY? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 58. DURING THE LAST YEAR HAS THIS FEELING CAUSED PROBLEMS WITH YOUR FAMILY/PERSONAL LIFE? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 59. DOES THIS FEELING INTERFERE WITH YOUR SOCIAL ACTIVITIES? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

PSYDYS 60. DURING THE LAST YEAR HAVE YOU EVER HAD TO STAY AT HOME OR IN BED BECAUSE OF THIS FEELING? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
PSYDYS 61. DURING THE LAST YEAR WERE YOU UNABLE TO DO YOUR USUAL WORK AT ANY TIME BECAUSE OF FEELING THAT YOU MIGHT HAVE A NERVOUS BREAKDOWN? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
ASK EVERYONE:			
DEP ANX 62. HAVE YOU EVER HAD PERIODS OF DAYS OR WEEKS WHEN YOU COULDN'T GET GOING? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 63. HOW OFTEN WOULD YOU SAY THINGS DON'T TURN OUT THE WAY YOU WANT THEM TO? WOULD YOU SAY: (Don't read "always turn out").		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 (always turn out) 7 Don't know 8 Not answered 9 Not applicable

DEP 64. WHEN THINGS DON'T TURN OUT, HOW OFTEN WOULD YOU BLAME YOURSELF?		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 65. HOW OFTEN DO YOU HAVE CRYING SPELLS OR FEEL LIKE IT? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 66. HOW OFTEN DO YOU FEEL YOU DON'T ENJOY (DOING) THINGS ANY MORE? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometime 1 Seldom 0 Never feel that way 7 Don't know 8 Not answered 9 Not applicable
DEP 67. HOW OFTEN DO YOU FEEL ALONE AND HELPLESS? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

DEP 68. HOW OFTEN DO YOU FEEL THAT PEOPLE DON'T CARE WHAT HAPPENS TO YOU? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 69. HOW OFTEN DO YOU FEEL THAT LIFE IS HOPELESS? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 70. HOW DOES THE FUTURE LOOK TO YOU? WOULD YOU SAY:		—	0 Excellent 1 Good 2 Fair 3 Poor 4 Bad 7 Don't know 8 Not answered 9 Not applicable
DEP 71. HOW OFTEN DO YOU THINK OF SUICIDE? WOULD YOU SAY:		—	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

CI 72. HOW OFTEN DO YOU HAVE TROUBLE CONCENTRATING OR KEEPING YOUR MIND ON WHAT YOU ARE DOING? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 73. HOW OFTEN DO YOU HAVE UNWELCOME OR STRANGE THOUGHTS OR THOUGHTS THAT FRIGHTEN YOU? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 74. HOW OFTEN DO YOU FIND YOURSELF DOING THE SAME THINGS OVER AND OVER TO BE SURE THEY ARE RIGHT? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 75. HOW OFTEN DO YOU GET UPSET, UPTIGHT OR IRRITABLE WITH THOSE AROUND YOU? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

CI 76. HOW OFTEN DO YOU HAVE TROUBLE REMEMBERING THINGS? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
CI 77. If response is other than NEVER, ask: DOES IT CAUSE YOU DIFFICULTY? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
CI 78. If response is other than NEVER, ask: DOES IT KEEP YOU FROM DOING SOME THINGS YOU WANT TO DO? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 79. HOW OFTEN DO YOU FEEL THAT PEOPLE ARE TRYING TO PICK QUARRELS OR START ARGUMENTS WITH YOU? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

GP 80. HOW OFTEN DO YOU THINK PEOPLE ARE FOLLOWING YOU OR PLOTTING AGAINST YOU? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 81. HOW OFTEN DO YOU GET REALLY ANGRY? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 82. HOW OFTEN DO THINGS NOT SEEM REAL TO YOU OR DO YOU HAVE FEELINGS THAT YOU ARE NOT REALLY HERE? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
GP 83. HOW OFTEN DO YOU SEE OR HEAR THINGS THAT OTHER PEOPLE DON'T THINK ARE THERE? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable

DEP 84. HOW OFTEN DO YOU HAVE TROUBLE WITH SLEEPING? WOULD YOU SAY:		___	4 All the time 3 Often 2 Sometimes 1 Seldom 0 Never 7 Don't know 8 Not answered 9 Not applicable
DEP 85. LIFE HAS CHANGED SO MUCH IN OUR MODERN WORLD THAT PEOPLE ARE POWERLESS TO CONTROL THEIR OWN LIVES. WOULD YOU:		___	4 Strongly agree 3 Agree 2 Undecided 1 Disagree 0 Strongly disagree 7 Don't know 8 Not answered 9 Not applicable
(Not a scale item) 86. HOW WOULD YOU RATE YOUR NERVES, SPIRITS, OUTLOOK, OR MENTAL HEALTH AT PRESENT?		___	4 Excellent 3 Good 2 Fair 1 Poor 0 Very bad 7 Don't know 8 Not answered 9 Not applicable
HOS 87. ARE YOU EVER BOTHERED BY NIGHT-MARES (DREAMS WHICH FRIGHTEN YOU)? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable

HOS 88. DO YOU SMOKE? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
HOS 89. DO YOU TEND TO LOSE WEIGHT WHEN YOU WORRY? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
HOS 90. HOW OFTEN ARE YOU BOTHERED BY HAVING AN UPSET STOMACH? WOULD YOU SAY:		___	4 Often 2 Sometimes 0 Never 7 Don't know 8 Not answered 9 Not applicable
91. DO YOU KNOW THE LOCATION OF A LOCAL COMMUNITY MENTAL HEALTH CENTER?		___	*1 Yes 2 No 8 Not answered 9 Not applicable
92. IN RANK ORDER, WHO WOULD YOU INITIALLY SEEK HELP FROM IF YOU OR ANY MEMBER OF YOUR FAMILY HAS AN EMOTIONAL OR MENTAL HEALTH RELATED PROBLEM?		___ ___ ___ ___ ___ ___	A Community Mental Health Center A priest Relatives Friends No one/self Other: Please specify _____ 9 Not ranked

Interviewer's Instructions:

If a community mental health center does not rank first, then ask Question 93.

93. WHAT PREVENTS YOU FROM INITIALLY SEEKING HELP FROM A COMMUNITY HEALTH CENTER?		___	Embarrassment
		___	Fear
		___	Language Barriers
		___	Financial
		___	Transportation
		___	Unaware of existence of services
		___	Other: Please specify_____
		___	9 Not applicable